

This electronic thesis or dissertation has been downloaded from the King's Research Portal at <https://kclpure.kcl.ac.uk/portal/>



**A mixed-methods study to evaluate the feasibility and acceptability of delivering an intervention to support women with experiences of interpersonal abuse, post-traumatic stress disorder symptoms, and substance use, within an English substance use service.**

Bailey, Karen Michelle Alice

*Awarding institution:*  
King's College London

The copyright of this thesis rests with the author and no quotation from it or information derived from it may be published without proper acknowledgement.

#### END USER LICENCE AGREEMENT



**Unless another licence is stated on the immediately following page** this work is licensed

under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International

licence. <https://creativecommons.org/licenses/by-nc-nd/4.0/>

You are free to copy, distribute and transmit the work

Under the following conditions:

- Attribution: You must attribute the work in the manner specified by the author (but not in any way that suggests that they endorse you or your use of the work).
- Non Commercial: You may not use this work for commercial purposes.
- No Derivative Works - You may not alter, transform, or build upon this work.

Any of these conditions can be waived if you receive permission from the author. Your fair dealings and other rights are in no way affected by the above.

#### Take down policy

If you believe that this document breaches copyright please contact [librarypure@kcl.ac.uk](mailto:librarypure@kcl.ac.uk) providing details, and we will remove access to the work immediately and investigate your claim.

**A MIXED-METHODS STUDY TO EVALUATE THE  
FEASIBILITY AND ACCEPTABILITY OF DELIVERING  
AN INTERVENTION TO SUPPORT WOMEN WITH  
EXPERIENCES OF INTERPERSONAL ABUSE, POST-  
TRAUMATIC STRESS DISORDER SYMPTOMS, AND  
SUBSTANCE USE, WITHIN AN ENGLISH SUBSTANCE  
USE SERVICE.**

**Karen M. A. Bailey**

**Addictions Department**

**Institute of Psychiatry, Psychology, &  
Neuroscience**

**Thesis submitted to King's College London for the  
degree of Doctor of Philosophy (PhD)**

**January 2019**

## Abstract

**Background and aims:** Women with interpersonal abuse (IPA) histories experience high levels of post-traumatic stress disorder (PTSD) and substance use. UK substance use treatment services lack integrated responses and trauma-informed practice (TIP). This thesis determined the feasibility of delivering and evaluating an integrated trauma-specific group intervention within routine substance use treatment in England.

**Methods:** Mixed methods were employed: a narrative systematic review of 20 international controlled trials examined the evidence base (Phase 1); thematic analysis of 25 semi-structured interviews with UK and US stakeholders explored delivery of trauma-specific interventions (Phase 2); Seeking Safety was adapted, using Behaviour Change Theory (Phase 3). The feasibility of delivering the adapted Seeking Safety intervention was evaluated with participants (n=19) and facilitators (Phase 4). Qualitative interviews, analysed using 'Framework', elicited their intervention experiences. Mental health, coping skills and substance use outcomes were measured post-intervention (T2) and 3-months post-intervention (T3).

**Results:** Phase 1) Present-focused interventions, concentrating on extensive safety and stabilisation coping skills, may be best suited to women with more severe PTSD and substance use, and those experiencing ongoing victimisation; Phase 2) UK stakeholders warned against tokenistic approaches to TIP. US stakeholders found Seeking Safety compatible with community-based substance use services; Phase 3) Seeking Safety adaptations included 12-sessions and additional mind-body activities; Phase 4) Seeking Safety was feasible and acceptable to participants (64% received the minimum-dose and 84% were followed-up at T3); concerns centred on group cohesion. Participants reported decreased PTSD symptoms and alcohol use, but not drug use. Service closure and ongoing victimisation negatively impacted on recovery.

**Conclusions:** Substance use services should respond to IPA. Present-focused integrated trauma-specific interventions, which include mind-body strategies, hold promise. Services require support to develop TIP in the face of funding cuts. Future Seeking Safety delivery should consider increasing session quantity, ensuring support for facilitators to adhere to intervention fidelity.

## Table of Contents

<b>ABSTRACT .....</b>	<b>2</b>
<b>ACKNOWLEDGEMENTS.....</b>	<b>14</b>
<b>DEFINITIONS.....</b>	<b>15</b>
<b>ABBREVIATIONS .....</b>	<b>18</b>
<b>CHAPTER 1: BACKGROUND.....</b>	<b>20</b>
PREVALENCE OF INTERPERSONAL ABUSE, PTSD SYMPTOMS, AND SUBSTANCE USE AMONG WOMEN .....	20
1.1 .....	20
1.2 ABUSE ACROSS THE LIFETIME AND ADVERSE OUTCOMES .....	23
1.3 THEORETICAL UNDERSTANDING OF THE LINKS.....	25
1.4 THE NEED FOR GENDER-RESPONSIVE TREATMENT.....	28
<b>CHAPTER 2: STUDY OUTLINE.....</b>	<b>33</b>
2.1 STUDY AIM AND OBJECTIVES .....	33
2.1.1 Overall study aim .....	33
2.1.2 Study Objectives.....	33
2.2 RATIONALE AND STUDY PHASES .....	35
2.2.1 Phase 1: A narrative systematic review (Chapter 3).....	35
2.2.2 Phase 2: Stakeholder consultation (Chapter 4) .....	35
2.2.3 Phase 3: Intervention adaptation and implementation considerations (Chapter 5).....	35
2.2.4 Phase 4: Feasibility study (Chapters 6-8).....	36
2.2.5 Other research designs.....	39
2.3 RESEARCH PARADIGMS AND MIXED METHODS DESIGN.....	39
2.4 THEORETICAL FRAMEWORKS INFLUENCING THE STUDY .....	45
2.4.1 Social-ecological model for violence against women.....	45
2.4.2 Staged model for the treatment of Complex PTSD.....	46
2.4.3 The COM-B theory of behaviour change .....	46



2.5 RESEARCHER REFLEXIVITY AND STANDPOINT .....	46
<b>CHAPTER 3: SYSTEMATIC REVIEW .....</b>	<b>49</b>
3.1 INTRODUCTION .....	49
3.1.1 <i>Justification for the systematic review</i> .....	49
3.1.2 <i>The importance of exploring evidence beyond treatment effect</i> .....	50
3.1.3 <i>Aim of the systematic review</i> .....	51
3.2. METHODOLOGY .....	51
3.2.1 <i>Search strategies</i> .....	51
3.2.2 <i>Selection criteria</i> .....	52
3.2.3 <i>Data extraction</i> .....	53
3.2.4 <i>Quality appraisal</i> .....	53
3.2.5 <i>Analysis</i> .....	54
3.3 RESULTS .....	55
3.3.1 <i>Study selection</i> .....	55
3.3.2 <i>Sample overview</i> .....	57
3.4. FINDINGS .....	67
3.4.1 <i>Subgroups</i> .....	70
3.4.2 <i>Contextual factors</i> .....	73
3.4.3 <i>Mechanisms of action in the interventions</i> .....	75
3.4.4 <i>Other mechanisms of action</i> .....	77
3.4.5 <i>Implementation considerations</i> .....	78
3.5. DISCUSSION .....	82
3.5.1 <i>Pathways to PTSD symptom and substance use reduction</i> .....	82
3.5.2 <i>The role of different coping skills</i> .....	83
3.5.3 <i>Attending to relations with self and others</i> .....	83
3.5.4 <i>Targeting emotional regulation</i> .....	84
3.5.5 <i>Implications of contextual factors for treatment implementation</i> .....	85
3.5.6 <i>Other implementation considerations</i> .....	86

3.5.7 <i>The value of present-focused integrated interventions</i> .....	88
3.5.8 <i>Conclusion</i> .....	88
<b>CHAPTER 4: STAKEHOLDER CONSULTATION</b> .....	<b>90</b>
4.1 INTRODUCTION .....	90
4.1.1 <i>International and UK policy</i> .....	90
4.1.2 <i>The purpose of stakeholder consultation</i> .....	91
4.1.3 <i>Qualitative research study objectives</i> .....	91
4.2 METHOD .....	92
4.2.1 <i>Theoretical assumptions</i> .....	92
4.2.2 <i>Design</i> .....	93
4.2.3 <i>Sample selection</i> .....	93
4.2.4 <i>Data collection</i> .....	94
4.2.5 <i>Data analysis</i> .....	96
4.3 FINDINGS: RESEARCH QUESTION 1 .....	101
4.3.1 <i>Description of stakeholders from England</i> .....	101
4.3.2 <i>Philosophical approach</i> .....	104
4.3.3 <i>Tailored clinical practice</i> .....	107
4.3.4 <i>Systemic responses</i> .....	112
4.4 FINDINGS: RESEARCH QUESTION 2 .....	115
4.4.1 <i>Description of stakeholders from the USA</i> .....	115
4.4.2 <i>Opinions of delivering TREM and Seeking Safety group-work</i> .....	118
4.4.3 <i>Responses to context</i> .....	121
4.4.4 <i>Additional research considerations</i> .....	126
4.5 DISCUSSION .....	127
4.5.1 <i>Philosophical approach driving service delivery</i> .....	127
4.5.2 <i>Extensive first stage safety and stabilisation work needed</i> .....	127
4.5.3 <i>Developing TIP in England</i> .....	128
4.5.4 <i>Focusing on systems</i> .....	129

4.5.5 Considerations for the next phases of the PhD .....	129
<b>CHAPTER 5: INTERVENTION REVIEW AND IMPLEMENTATION.....</b>	<b>131</b>
5.1 CHOICE OF SERVICE SETTING, STUDY PRACTITIONERS, AND INTEGRATED INTERVENTION.....	131
5.1.1 Choice of service setting.....	131
5.1.2 Evidence for TIP.....	132
5.1.3 Choice of study practitioners.....	134
5.1.3 Choice of integrated intervention.....	135
5.1.4 About Seeking Safety .....	137
5.2 SEEKING SAFETY REVIEW AND ADAPTATIONS .....	137
5.2.1 Choice of group-work format .....	138
5.2.2 Seeking Safety topics.....	139
5.2.3 Group consensus exercise .....	140
5.2.4 Seeking Safety material review .....	145
5.2.3 Pre-orientation session.....	147
5.3 USING BEHAVIOUR CHANGE THEORY TO GUIDE THE SEEKING SAFETY REVIEW.....	148
5.3.1 Identifying the target behaviours for change.....	149
5.3.2 Changes required to promote the targeted behaviours.....	150
5.3.3 Identifying intervention functions and BCTs.....	152
5.4 TRAINING .....	153
5.4.1 Seeking Safety fidelity monitoring training .....	153
5.4.2 Group facilitators training.....	153
5.4.3 Training for all staff in the study treatment service.....	153
5.5 LOGIC MODEL FOR THE INTERVENTION .....	154
<b>CHAPTER 6: FEASIBILITY STUDY METHODOLOGY .....</b>	<b>156</b>
6.1 SETTING AND INTERVENTION .....	157
6.1.1 Minimal session dose .....	157
6.2 PARTICIPANT ELIGIBILITY CRITERIA.....	158
6.2.1 Inclusion criteria.....	158

6.2.2 Exclusion criteria .....	158
6.3 IDENTIFICATION AND RECRUITMENT OF STUDY POPULATION .....	159
6.3.1 Service user involvement.....	160
6.4 SCREENING ASSESSMENT.....	160
6.5 SAMPLE SIZE .....	161
6.6 STUDY MEASURES.....	162
6.6.1 Process evaluation measures .....	166
6.7 DATA COLLECTION.....	167
6.7.1 Trialling the structured questionnaires .....	167
6.7.2 Quantitative data collection: structured questionnaires.....	167
6.7.3 Qualitative data collection .....	168
6.8 QUANTITATIVE DATA ANALYSIS.....	171
6.8.1 Data entry .....	171
6.8.2 Descriptive data .....	172
6.8.3 Statistical analysis.....	172
6.9 QUALITATIVE DATA ANALYSIS .....	174
6.9.1 Data set.....	174
6.9.2 Data analysis.....	174
6.10 MIXED METHODS DATA ANALYSIS .....	178
6.10.1 Confirm and Discover: quantitative analysis informed by the qualitative data .....	179
6.10.2 Completeness and Triangulation.....	179
6.10.3 Explanation .....	179
6.10.4 Context.....	180
6.10.5 Addressing ‘validity’ in mixed methods design.....	180
6.11 ETHICS AND PARTICIPANT AND RESEARCHER SAFETY.....	181
6.11.1 Amendments approved .....	181
6.11.2 Informed Consent.....	181
6.11.3 Confidentiality and data protection .....	182
6.11.4 Limitations to confidentiality .....	183

6.11.5 Internal audit – serious adverse event .....	185
6.11.6 Safety in communication with study participants .....	185
6.11.7 Minimising distress from participating in the study.....	186
6.12 LIMITS OF THE FEASIBILITY STUDY DESIGN .....	187
<b>CHAPTER 7: FEASIBILITY STUDY RESULTS: PART ONE .....</b>	<b>188</b>
7.1 FEASIBILITY OF RECRUITMENT, RETENTION AND STUDY MEASURES .....	188
7.1.1 Recruiting participants .....	189
7.1.2 Feasibility of study eligibility criteria.....	191
7.1.3 Ability to recruit target population: participant characteristics.....	192
7.1.4 Study retention.....	197
7.1.5 Group retention.....	200
7.1.6 Suitability and acceptability of the study measures.....	202
7.2 IMPLEMENTATION OF SEEKING SAFETY: STAFF PERCEPTIONS .....	205
7.2.1 Pre-implementation .....	205
7.2.2 Fidelity monitoring process .....	207
7.3 SUBJECT MATTER.....	215
7.3.1 Core content.....	215
7.3.2 The new ‘mind-body’ components .....	218
7.4 GROUP DYNAMIC .....	220
7.4.1 Group Cohesion and therapeutic alliance .....	220
7.5 INTERVENTION STRUCTURE .....	229
7.5.1 General format.....	229
7.5.2 Structural components .....	232
7.5.3 Recommendations for changes to structure .....	234
7.6 SUMMARY .....	236
<b>CHAPTER 8: FEASIBILITY STUDY RESULTS: PART TWO .....</b>	<b>238</b>
8.1 PARTICIPANT OUTCOMES: QUANTITATIVE MEASURES .....	238
8.1.1 Introduction.....	238

8.1.2 PTSD symptoms.....	239
8.1.3 Clinically meaningful change in PTSD symptoms .....	239
8.1.4 Change in PTSD symptoms according to number of sessions attended (minimal dose) .....	243
8.1.5 Emotional regulation and depression .....	243
8.1.6 Coping skills, social support, and self-esteem .....	244
8.1.7 Correlations between coping skills and PTSD symptoms .....	244
8.1.8 Correlations between depression and PTSD symptoms .....	245
8.1.9 Drug and alcohol use.....	246
8.1.10 Negative trauma cognitions.....	247
8.1.11 Exposure to recent IPA on PTSD outcomes.....	248
8.2 PARTICIPANT OUTCOMES: QUALITATIVE DATA .....	249
8.2.1 Introduction.....	249
8.2.2 Emotional wellbeing.....	252
8.2.3 Changes in substance use.....	258
8.2.4 Relationships with others.....	261
8.3 CONTEXTUAL FACTORS .....	264
8.3.1 Introduction.....	264
8.3.2 Individuals' characteristics .....	264
8.3.3 Service environment.....	266
8.3.4 Stressful events and IPA .....	272
8.4 SUMMARY .....	274
<b>CHAPTER 9: DISCUSSION .....</b>	<b>277</b>
9.1 INTRODUCTION .....	277
9.2 IMPLEMENTATION CONSIDERATIONS .....	280
9.2.1 Relevance and utility of Seeking Safety content.....	280
9.2.2 Seeking Safety format .....	288
9.2.3 Seeking Safety process .....	290
9.2.4 Responding to context.....	298

9.3 CONSIDERATIONS FOR FUTURE FEASIBILITY STUDIES .....	307
9.3.1 <i>Recruiting eligible participants</i> .....	307
9.3.2 <i>Aides to recruitment</i> .....	310
9.3.3 <i>Aides to study and group retention</i> .....	311
9.3.4 <i>Improvements to study measures</i> .....	313
9.3.5 <i>Service user involvement in research</i> .....	315
9.3.7 <i>Fidelity monitoring in future research</i> .....	317
9.4 RECOMMENDATIONS FOR PRACTICE, POLICY, AND RESEARCH.....	318
9.4.1 <i>Practice – developing TIP and trauma-specific interventions</i> .....	318
9.4.2 <i>Practice – Seeking Safety specific</i> .....	319
9.4.3 <i>Policy</i> .....	320
9.4.4 <i>Future research</i> .....	320
9.5 STRENGTHS AND LIMITATIONS OF THE PhD STUDY .....	321
9.5.1 <i>Phase 1 Systematic review: strengths</i> .....	321
9.5.2 <i>Phase 1 Systematic review: limitations</i> .....	322
9.5.3 <i>Phase 2 Stakeholder consultation: strengths</i> .....	323
9.5.4 <i>Phase 2 Stakeholder consultation: limitations</i> .....	324
9.5.5 <i>Phase 4 Feasibility study: strengths</i> .....	324
9.5.6 <i>Phase 4 Feasibility study: limitations</i> .....	326
9.6 SUMMARY AND CONCLUSIONS .....	329
<b>REFERENCES .....</b>	<b>331</b>
APPENDIX 1: PRINCIPLES OF TRAUMA INFORMED SERVICES.....	367
APPENDIX 2: SEARCH STRATEGIES FOR SCOPING EXERCISE, STAGE 1 AND 2 SEARCHES. ....	368
APPENDIX 3: SUB-CODES CREATED IN THE NARRATIVE REVIEW USING THEMATIC ANALYSIS .....	374
APPENDIX 4: OVERVIEW OF TRAUMA-SPECIFIC MODELS IDENTIFIED IN THE SYSTEMATIC REVIEW.....	375
APPENDIX 5: INCLUSION/EXCLUSION CRITERIA USED FOR RECRUITING THE INTERVIEW SAMPLE FROM ENGLAND .....	379
APPENDIX 7: CONFIRMATION OF ETHICS APPROVAL FROM SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	381
APPENDIX 8: CONFIRMATION OF ETHICS APPROVAL FROM CAMDEN AND ISLINGTON NHS FOUNDATION TRUST .....	382

APPENDIX 9: PRACTITIONERS TOPIC GUIDE USED IN STAKEHOLDER INTERVIEWS .....	383
APPENDIX 10: RESEARCHER TOPIC GUIDE USED IN STAKEHOLDER INTERVIEWS .....	385
APPENDIX 11: INITIAL CODEBOOK USED FOR THE QUALITATIVE INTERVIEW DATA WITH PRACTITIONERS IN ENGLAND .....	387
APPENDIX 12: INITIAL CODEBOOK USED FOR THE QUALITATIVE INTERVIEW DATA WITH PRACTITIONERS IN USA.....	389
APPENDIX 13: PROPOSED AMENDMENTS TO THE SEEKING SAFETY HAND-OUTS .....	390
APPENDIX 14: COM-B AND TDF DOMAINS RELEVANT TO THE INTERVENTION .....	394
APPENDIX 15: USING BEHAVIOUR CHANGE TECHNIQUES TO REVIEW THE SEEKING SAFETY INTERVENTION AND IMPLEMENTATION .....	396
APPENDIX 16: SEEKING SAFETY ADHERENCE SCALE .....	403
APPENDIX 17: OUTLINE OF SEEKING SAFETY TRAINING PROVIDED TO THE GROUP FACILITATORS.....	416
APPENDIX 18: PARTICIPANT INFORMATION SHEET.....	418
APPENDIX 19: PARTICIPANT CONSENT FORMS .....	422
APPENDIX 20: STUDY ADVERTISEMENT.....	424
APPENDIX 21: FEASIBILITY STUDY MEASURES.....	425
APPENDIX 22: WCDVS VERSION OF THE LIFE-STRESSOR CHECKLIST-REVISED .....	433
APPENDIX 23: FOCUS GROUP TOPIC GUIDE .....	441
APPENDIX 24: SEMI-STRUCTURED INTERVIEW TOPIC GUIDE 1 .....	442
APPENDIX 25: SEMI-STRUCTURED INTERVIEW TOPIC GUIDE 2 .....	443
APPENDIX 26: SEMI-STRUCTURED INTERVIEW TOPIC GUIDE (SERVICE MANAGER) .....	445
APPENDIX 27: INITIAL 'FRAMEWORK' DEVELOPED IN THE EARLY STAGES OF QUALITATIVE DATA MANAGEMENT .....	446
APPENDIX 28: 'ABSTRACTION AND INTERPRETATION STAGE' OF QUALITATIVE DATA ANALYSIS .....	447
APPENDIX 29: SUMMARY OF 'DETECTED ELEMENTS AND KEY DIMENSIONS' IN QUALITATIVE DATA ANALYSIS .....	449
APPENDIX 30: THEMES IDENTIFIED IN THE FINAL STAGE OF QUALITATIVE ANALYSIS. ....	453
APPENDIX 31: CONFIRMATION OF ETHICS APPROVAL FOR THE FEASIBILITY STUDY FROM KINGS COLLEGE LONDON.....	459
APPENDIX 32: RESEARCHER SAFETY PROTOCOL .....	460
APPENDIX 33: CALPAS SUB-SCALE SCORES .....	462
APPENDIX 34: QUALITATIVE FEEDBACK FOR THE SEEKING SAFETY GROUP COMPONENTS .....	463
APPENDIX 35: SUMMARY AND NON-PARAMETRIC TEST STATISTICS FOR STUDY MEASURES .....	465



TABLE 1: THE MIXING OF METHODS ACROSS THE DIFFERENT PHASES OF THE PhD.....	41
TABLE 2: SUMMARY OF STUDIES IDENTIFIED IN STAGE ONE AND THEIR ASSOCIATED SUPPLEMENTARY STUDIES .....	59
TABLE 3: FINAL SAMPLE OF THE 14 STAKEHOLDERS INTERVIEWED FROM ENGLAND .....	102
TABLE 4: FINAL SAMPLE OF THE 11 STAKEHOLDERS INTERVIEWED FROM THE USA .....	116
TABLE 5: STRENGTHS AND WEAKNESSES OF TREM AND SEEKING SAFETY.....	135
TABLE 6: TOPIC SELECTION BASED ON FIRST ROUND VOTES IN CONSENSUS EXERCISE .....	141
TABLE 7: FINAL SELECTION OF TOPICS AND THEIR CONTENT CATEGORY .....	145
TABLE 8: CONSTRUCTS MEASURED IN THE FEASIBILITY STUDY INFORMED BY PREVIOUS PHASES OF THE PhD STUDY .....	163
TABLE 9: SUMMARY OF MEASURES AND ADMINISTRATION TIME-POINTS IN THE FEASIBILITY STUDY .....	164
TABLE 10: SOCIO-DEMOGRAPHICS AND GENERAL BACKGROUND CHARACTERISTICS OF THE STUDY PARTICIPANTS .....	193
TABLE 11: TRAUMA, SUBSTANCE USE, AND MENTAL HEALTH EXPERIENCES OF THE STUDY PARTICIPANTS .....	194
TABLE 12: SCORING OF THE SEEKING SAFETY ADHERENCE SCALE FOR GROUP 2 .....	210
TABLE 13: PARTICIPANT RATINGS OF CORE FOUNDATIONS OF THE SEEKING SAFETY INTERVENTION* .....	218
TABLE 14: PARTICIPANT SCORES FOR GROUP COHESION.....	226
TABLE 15: PARTICIPANT SCORES FOR THERAPEUTIC ALLIANCE WITH THE TWO GROUP FACILITATORS.....	228
TABLE 16: PARTICIPANT RATINGS OF CORE COMPONENTS OF THE SEEKING SAFETY FORMAT* .....	233
TABLE 17: SUMMARY AND TEST STATISTICS FOR STUDY MEASURES USING REPEATED MEASURES ANOVA.....	242
TABLE 18: WRAP-AROUND CARE RECEIVED BY THE PARTICIPANTS WHILST PARTICIPATING IN THE STUDY .....	268

FIGURE 1: CONCEPTUAL FRAMEWORK FOR FEASIBILITY STUDIES.....	37
FIGURE 2: MRC FRAMEWORK FOR THE DEVELOPMENT AND EVALUATION OF COMPLEX INTERVENTIONS .....	38
FIGURE 3: FLOWCHART OF STUDY PHASES USING MIXED METHODS QUANTITATIVE (QUANT) AND QUALITATIVE (QUAL) ...	44
FIGURE 4: SOCIO-ECOLOGICAL MODEL OF VIOLENCE AGAINST WOMEN .....	45
FIGURE 5: PRISMA FLOWCHART OF TWO-STAGE SEARCH STRATEGY FOR THE SYSTEMATIC REVIEW .....	56
FIGURE 6: THEMATIC MAPPING OF THE KEY THEMES IN THE SYSTEMATIC REVIEW NARRATIVE ANALYSIS.....	69
FIGURE 7: EARLY THEMATIC MAP USED TO SUPPORT ANALYSIS OF THE STAKEHOLDER INTERVIEWS FROM ENGLAND.....	98
FIGURE 8: THEMATIC MAPPING RELATED TO PRACTITIONER EXPERIENCES OF PROVIDING CARE TO ADDRESS INTERPERSONAL ABUSE, PTSD SYMPTOMS, AND SUBSTANCE USE AMONG WOMEN IN ENGLAND .....	103
FIGURE 9: THEMATIC MAP OF STUDY IMPLEMENTATION CONSIDERATIONS DERIVED FROM US STAKEHOLDERS .....	117
FIGURE 10: BEHAVIOUR CHANGE TARGETS AND THE WIDER EXTERNAL INFLUENCES/CONTEXTS .....	150
FIGURE 11: COM-B MODEL .....	151
FIGURE 12: LOGIC MODEL FOR DELIVERY OF THE SEEKING SAFETY INTERVENTION.....	155
FIGURE 13: MAPPING USED TO DEVISE THE FINAL SET OF THEMES IN THE ANALYSIS OF PARTICIPANT INTERVIEWS .....	178
FIGURE 14: CONSORT FLOWCHART OF STUDY PARTICIPANTS .....	199
FIGURE 15: MAP OF KEY FINDINGS RELATING TO ACCEPTABILITY OF SEEKING SAFETY .....	214
FIGURE 16: IMPROVEMENTS OVER TIME FOR PTSD, DEPRESSION, AND EMOTIONAL REGULATION SCORES .....	240
FIGURE 17: IMPROVEMENTS OVER TIME FOR SCORES OF COPING SKILLS, SOCIAL SUPPORT, AND SELF-ESTEEM .....	241
FIGURE 18: IMPROVEMENTS IN MEAN PTSD SCORES OVER TIME ACCORDING TO GROUP SESSIONS ATTENDED .....	243
FIGURE 19: CORRELATION BETWEEN COPINGS SKILLS AND PTSD SYMPTOMS AT 3-MONTHS POST-INTERVENTION FOLLOW-UP .....	245
FIGURE 20: CORRELATION BETWEEN PTSD AND DEPRESSION SCORES AT 3-MONTHS POST-INTERVENTION FOLLOW-UP ....	246
FIGURE 21: BOX PLOTS FOR THE IMPROVEMENTS IN ALCOHOL USE SCORES OVER TIME .....	247
FIGURE 22: BOX PLOTS FOR THE IMPROVEMENT IN NEGATIVE TRAUMA COGNITIONS OVER TIME .....	248
FIGURE 23: IMPROVEMENTS IN MEAN PTSD SCORES OVER TIME ACCORDING TO NEW EXPOSURE TO IPA SINCE BASELINE..	249
FIGURE 24: THEMATIC MAP ILLUSTRATING PARTICIPANT OUTCOMES AND CONTEXTUAL FACTORS IMPACTING ON OUTCOMES .....	251
FIGURE 25: THE WINDOW OF AFFECTIVE TOLERANCE .....	284

## Acknowledgements

I dedicate this thesis to my mother who had unwavering faith that I could do anything I set my mind to and encouraged me to think the same.

To my supervisors, Dr Gail Gilchrist and Dr Kylee Trevillion: thank you for caring about this subject, for *always* being there when I needed you, often going above and beyond, and showing me how to be a better researcher.

To the group facilitators: thank you for joining me on this journey, and your commitment to helping women.

To the study treatment service staff: thank you for making me feel welcome and helping me when I needed it.

To Dr Tim Meynen: thank you for helping me guard against the heaviness and sadness that can accompany this work.

To my partner A: thank you for your love and perseverance in weathering the storms with me and spurring me on to be strong.

To my friends, family, and fellow PhD colleagues: thank you for the wonderful acts of kindness.

And finally, to the women who participated in the study, especially those who did so because they wanted to help improve the treatment system for others like them: thank you for your courage and bravery.

## Definitions

### Interpersonal abuse (IPA)

Within this PhD study, the term IPA is used to encompass the various forms of violence that are directed at women because they are women, or affect them disproportionately, including intimate partner violence, domestic violence, childhood and adult physical, emotional and sexual abuse and exploitation, as well as stalking and sexual trafficking (the forced movement of people for sexual exploitation).

### Domestic violence and intimate partner violence

Domestic violence is defined here as: any incident of threatening behaviour, violence, or abuse (psychological, physical, sexual, financial or emotional) between adults (aged  $\geq 16$  years) who are or have been intimate partners (intimate partner violence) or family members (domestic violence) regardless of gender or sexuality.

### Trauma

The UK clinical guidelines for PTSD refer to international definitions of trauma or traumatic events (NICE, 2018). The US Substance Abuse and Mental Health Services Administration [SAMHSA] defines 'trauma' as resulting from, *'an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.'* (SAMHSA 2014, p.1-1). Traumatic events may comprise a single incident or repeated multiple events over a person's lifetime.

### Post-traumatic Stress Disorder (PTSD)

For a person's experience of trauma to result in PTSD according to the Diagnostic and Statistical Manual of Mental Disorders (5<sup>th</sup> edition; DSM-5, American Psychiatric Association, 2013), it is a requirement that specific and certain forms of trauma (death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence) are experienced in the following way(s):

- Direct exposure

- Witnessing the trauma
- Learning that a relative or close friend was exposed to a trauma
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics).

In addition, the person must report at least one symptom relating to re-experiencing of the traumatic event (e.g., flashbacks, unwanted upsetting memories, nightmares); one symptom relating to the avoidance of trauma-related stimuli after the trauma; two symptoms relating to negative thoughts or feelings that began or worsened after the trauma (e.g., exaggerated blame of self or others for causing the trauma, negative affect, feeling isolated); and two symptoms linked to trauma –related arousal (e.g. irritability, hyper-vigilance, difficulty sleeping). All these symptoms should have lasted more than one month and create distress or functional impairment (social, occupational). Finally, these symptoms cannot be due to medication, substance use or other illness.

This PhD study will refer to women with a variety of traumatic symptoms, meeting criteria for both partial (sub-threshold) and full PTSD symptoms, and who may or may not have a formal clinical diagnosis of PTSD. In this PhD, the term 'PTSD symptoms' are used to encompass the spectrum of symptoms and the term 'PTSD' used when referring to the clinically diagnosed disorder.

### **Complex PTSD**

Complex PTSD symptoms are additional psychological symptoms which often result from repeated and prolonged IPA (e.g., childhood abuse or domestic violence) in comparison to other traumatic events (Cloitre et al., 2011; Herman, 2001). Whilst there is no formal diagnosis, the symptom clusters are sometimes referred to as Disorders of Extreme Stress Not Otherwise Specified (DESNOS) (Van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005). Experts are in common agreement that a person experiencing Complex PTSD symptoms have the following additional concerns on top of the defining PTSD symptoms described above: (a) emotion regulation difficulties, (b) disturbances in relational capacities, (c) alterations in attention and

consciousness (e.g., dissociation), (d) adversely affected belief systems, and (e) somatic distress or disorganization (Herman, 2001; van der Kolk et al., 2005).

### **Problematic substance use/Substance use**

Problematic substance use is used in this study to refer to the use of illegal or legal substances, including alcohol and prescribed medication, which results in psychological, physical, social or legal problems for the individual. As an umbrella term it includes the multifaceted terms encapsulated by the National Institute of Drug Abuse<sup>1</sup> and the different levels of severity or dependence encapsulated in the DSM-5 diagnosis of Substance Use Disorder (SUD) (American Psychiatric Association, 2013). According to the DSM-5, a diagnosis of SUD is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. Where the literature specifically refers to the treatment population as being clinically diagnosed with a SUD, this term will be used. In the PhD intervention study, assessment for SUDs according to DSM criteria was not used, and therefore the more general term of problematic substance use was employed, and for sake of brevity shortened to 'substance use' throughout the chapters.

### **Trauma-Informed Practice (TIP)**

TIP is,

“A strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both [service] providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.” (Hopper, Bassuck, & Olivet, 2010, p. 133).

---

<sup>1</sup> National Institute on Drug Abuse. Commonly Used Terms in Addiction Science. 2014. Available at [www.drugabuse.gov/publications/media-guide/glossary](http://www.drugabuse.gov/publications/media-guide/glossary)

## Abbreviations

A&E	Accident and Emergency
ACE	Adverse Childhood Experiences
ACMD	Advisory Council on the Misuse of Drugs
APA	Adult Physical Abuse
ASA	Adult Sexual Abuse
BCT	Behaviour Change Technique
CBT	Cognitive Behavioural Therapy
CI	Confidence Interval
CONSORT	Consolidated Standards of Reporting Trials
CPA	Childhood Physical Abuse
CSA	Childhood Sexual Abuse
DoH	Department of Health, England
DV	Domestic violence
DSV	Domestic and sexual violence
EMDR	Eye Movement Desensitisation and Reprocessing
ICBT	Integrated Cognitive Behavioural Therapy
IDVA	Independent Domestic Violence Advisor
IPA	Interpersonal Abuse
KCL	King's College London

MARAC	Multi-Agency Risk Assessment Conference
NHS	National Health Service, UK
NICE	National Institute of Health and Care Excellence
NIHR	National Institute of Health Research
PTSD	Post-traumatic Stress Disorder
OR	Odds Ratio
SAMHSA	Substance Abuse and Mental Health Services Administration, United States of America
SD	Standard Deviation
SE	Standard Error
SUD(s)	Substance Use Disorder(s)
TIP	Trauma Informed Practice
TREM	Trauma Recovery and Empowerment Model
US	United States
USA	United States of America
WCDVS	Women and Co-occurring Disorders and Violence Study



## **Chapter 1: Background**

This chapter will provide a brief overview of the prevalence estimates for women with experiences of interpersonal abuse (IPA), problematic substance use (here-after 'substance use') and co-occurring symptoms of post-traumatic stress disorder (PTSD), as well as a discussion of the complex interplay of these experiences and conditions. Competing models to explain the co-occurrence are also presented together with their supporting evidence. This overview provides the broader context in which the PhD study is situated and highlights the importance and justification for the focus on improving treatment for this population. The chapter will conclude with an outline of the current practice and policy environment in England for trauma informed practice (TIP) and trauma-specific interventions. The evidence on interventions to address these co-occurring issues will be systematically reviewed in Chapter 3.

### **1.1 Prevalence of interpersonal abuse, PTSD symptoms, and substance use among women**

Women in the general population are more likely to experience psychological, physical, financial and sexual intimate partner violence; and childhood and adult physical, emotional and sexual abuse and exploitation, in comparison to men; and especially abuse that is repeated and extensive in nature (Gadd, Farrall, Dallimore & Lombard, 2002; Myhill, 2015; Pinheiro, 2006; Walby & Allen, 2004). In a random probability sample of over 6000 children and young people in the UK, girls and young women, across all ages, were at higher risk of childhood contact sexual abuse compared to boys and young men (25.6% vs 7.9%) (Radford et al., 2010). The UK Adult Psychiatric Morbidity Survey, of a representative sample of 7,400 men and women across England, found that 28% of women compared to 19% of men had experienced intimate partner violence (Jonas et al., 2014). Moreover, 84% of those who had experienced 'extensive physical and sexual violence' were female (Natcen Social Research, 2013). The Crime Survey for England and Wales found that of people subject to four or more incidents of intimate partner violence from the same perpetrator, 89% were women (Walby & Allen, 2004); and women were more likely to experience coercive control (Myhill, 2015) and represent the majority of domestic homicide victims (Flatley, 2017).

Compared to women in the general population, women using substances experience higher rates of IPA, which can be as high as 70% depending on the study (El-Bassel, Gilbert, & Hill, 2005; Fowler et al., 2007; Gilchrist, Blázquez, & Torrens, 2012; Gutierrez & Van Puymbroeck, 2006; Humphreys, Thiara, & Regan 2005; LaFlair et al., 2012;). Compared to men seeking substance use treatment in the UK, women seeking treatment were more likely to be involved in sex trading in the past year (15% versus 2%) (Gilchrist, Singleton, Donmall, & Jones, 2015); substance users engaged in sex trading report higher IPA (Gilchrist et al., 2005). In a population-based sample of 1411 female adult twins, experiences of childhood sexual abuse involving rape resulted in increased odds of all psychiatric disorders measured but were the highest for SUDs (Alcohol=OR 4.01, 95%CI 2.33-6.91; Drugs=OR 5.70, 95%CI 3.04-10.69) (Kendler et al., 2000). A longitudinal study, with a random sample of 416 women in methadone maintenance programmes, demonstrated that women who reported intimate partner violence were 2.7 times more likely to report frequent heroin use in the subsequent six months, compared to women reporting no intimate partner violence (El-Bassel et al., 2005). A recent cross-sectional survey of 226 women who inject drugs, recruited across 5 European regions, identified that 69% had experienced intimate partner violence in the past 12-months, with 51% reporting severe levels (Tirado-Munoz et al., 2018). Similarly, women who have experienced intimate partner violence have also reported higher levels of drug and alcohol use, compared to women in who have not experienced such abuse (Eby, 2004; Humphries et al., 2005; Fowler et al., 2007). A US cohort study of 11,782 women found that women with a recent history of intimate partner violence had nearly six times the risk of problematic alcohol use, as compared to those with no history (LaFlair et al., 2012). Studies of women residing in refuges in both the UK and USA have also indicated higher substance use prevalence rates, compared to women in the general population (Humphries et al., 2005; Fowler et al., 2007).

US data shows that between 30-59% of women receiving substance use treatment have current PTSD (Dansky, Saladin, Brady, Kilpatrick, & Resnick, 1995; Najavits, Weiss & Shaw, 1997) compared to estimates of between 13-36% in community samples (Breslau, Davis, Andreski & Peterson 1991; Resnick, Kilpatrick, Dansky, Saunders, & Best 1993). PTSD among women with

SUDs is estimated to be two to three times higher than for men with SUDs (Hien, 2009). This may be due to the multiplicity of lifetime IPA that is associated with increased prevalence of both substance use and PTSD symptoms, as evidenced by large epidemiological studies (Natcen, 2013; Rees et al., 2011). The UK Adult Psychiatric Morbidity illustrates that 16% of those reporting extensive physical and sexual abuse as a child and adult screened positive for possible PTSD using a self-report measure, compared to 2% of those reporting no or little abuse, and 4% reporting CSA only. This same group also showed higher prevalence rates for self-reported alcohol (38%) and drug use problems (11%) compared to those with no or little abuse (23% and 3% respectively) and those reporting abuse in adulthood or childhood only (Natcen, 2013). Furthermore, people experiencing extensive abuse across the lifetime group were 15 times more likely to have attempted suicide. Limited data exist in the UK regarding substance use treatment populations with PTSD, especially disaggregated by gender; however, one small study of 51 clients (40% women) reported that 39% met the criteria for current PTSD diagnosis (Reynolds et al., 2005). European wide data of 226 women who inject drugs (including women from the UK), identified that 52% met criteria for PTSD (Tirado et al., 2018). Researchers have argued that some people experiencing traumatic events have debilitating PTSD symptoms although not meet the diagnostic criteria (Hien, 2009). In one literature review, the researchers found that people with sub-threshold symptoms still reported higher levels of functional impairment, risk of suicidality and hopelessness and substance use compared to non-PTSD samples (Brançu et al., 2016).

Research also shows that women who have experienced IPA, are more likely to experience mental health problems such as depression and PTSD, as well as showing suicidal or self-harming behaviours, compared to women who have not experienced such abuse (Galaif et al, 2001; Natcen, 2013, Trevillion, Oram, Feder, & Howard, 2012; Tirado et al., 2018). The UK Psychiatric Morbidity study found that in women but not men, physical intimate partner violence was significantly associated with common mental disorders such as anxiety and depression, eating disorders, and PTSD (Jonas et al., 2014). A robust systematic review incorporating a mixture of general, primary care and clinical populations found that women with depression or anxiety were at greater odds of experiencing intimate partner violence compared to counterparts without these conditions. Reported odds ratios were 3.31 (95%CI 2.35-4.68) and 2.29 (95%CI

1.31-4.02) respectively. The odds were also vastly increased for women with PTSD (7.34, 95%CI 4.50-11.96) (Trevillion et al., 2012). Alongside PTSD, depression is also commonly found among survivors of IPA. A systematic review of longitudinal studies found a bi-directional association between experiencing intimate partner violence and depression. There was evidence for the onset of depression and suicide attempts following physical and sexual violence, and evidence that depression may increase vulnerability to re-victimization (Devries et al., 2013). Furthermore, in the survey of female adult twins, those who had been raped as a child had three times the odds of experiencing two or more common mental health problems (OR 3.11, 95% CI 1.48-6.52) (Kendler et al., 2000). PTSD may be a particularly important treatment target for women because it has been implicated as a risk factor for first-onset depression in women (Breslau, Davis, Peterson & Schultz, 1997) and there is some suggestion that PTSD treatment improves other mental health conditions, including depression (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013).

## **1.2 Abuse across the lifetime and adverse outcomes**

Women experience re-victimisation in multiple ways including repeated abuse by the same person as a child or adult, and/or multiple forms of abuse experienced by different perpetrators (Etherington & Baker, 2017). Researchers and clinicians acknowledge the devastating impact of childhood trauma (Briere, 1992; Herman, 2001; van der Kolk et al., 2005, van der Kolk 2014). Research by Ford (2009) has described how brain systems underlying emotion regulation, cognitive processing, healthy attachment and interpersonal relationships are affected by early and repeated exposure to trauma. Furthermore, trauma-genic models of victimisation theorise that early trauma leads to children experiencing traumatic sexualisation, betrayal, stigmatisation, and powerlessness, which may shape their vulnerability to future victimisation (Finkelhor & Browne, 1985). However, such individualistic approaches can support a 'victim-blaming' culture and ignore the wider ecological factors which interact with individual characteristics to explain risk of (re)victimisation, such as poverty, societal norms, and constructions of masculinity/femininity (Etherington & Baker, 2017; Grauerholz, 2000; Heise, 1999).

In a robust meta-analysis of cross-sectional, case-control and cohort studies, adult outcomes most strongly associated with having experienced four or more adverse childhood experiences (ACEs)<sup>2</sup> were: violence, mental health, and problematic substance use. Adults with these experiences had vastly increased odds of both violence victimisation [OR=7.51, 95%CI 5.60–10.08), problematic alcohol [OR=5.84, 95%CI 3.99–8.56) and drug use [OR=10.22, 95%CI 7.62–13.71), suicide [OR=30.14, 95%CI 14.73–61.67), anxiety [OR=3.70, 95%CI 2.62–5.22] and depression [OR=4.40, 95%CI 3.54–5.46) (Hughes et al., 2017).

As adults, survivors of long-lasting traumatic events such as childhood trauma or intimate partner violence often experience symptoms found in common mental health diagnoses of depression, anxiety, and borderline personality disorder; such as poor concentration, self-loathing and hatred, trouble negotiating intimate relationships, cutting or purging, and dissociative symptoms (i.e., Complex PTSD symptoms). However, very rarely will these get acknowledged as Complex PTSD or Development Trauma (Courtois & Ford, 2009; Cloitre et al., 2009; Herman, 2001; Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997; Van der Kolk, 2014). There are ongoing debates about how Complex PTSD is assessed and whether it is a distinct diagnosable ‘disorder’ (Resick & Miller 2009 vs. Ford et al., 1999; Pelcovitz et al., 1997), questioning the need to assess for both. For example, in a small trial of an integrated trauma-specific intervention to address substance use and PTSD (n=19, 70% women), only 3% met the criteria for Complex PTSD, without PTSD (Triffleman, 2000).

Diagnostic debates aside, studies have also pointed to the impact of childhood cumulative trauma on adult severity and complexity of PTSD symptoms (Cloitre et al., 2009, Van der Kolk, 2014). The impact of previous abuse may be multiplicative in that current presenting psychological distress is a combination of ongoing distress from previous experiences, and that generated from current experiences. Alternatively, it may be interactive in that experiences of earlier trauma

---

<sup>2</sup> Adverse Childhood Experiences (ACES) include experiencing emotional, physical or sexual abuse, and living in homes with domestic violence or parental substance misuse (Hughes et al., 2017)

compound and magnify the impacts of current trauma or current trauma reactivates distress symptoms from childhood trauma (Briere and Jordan, 2004).

### **1.3 Theoretical understanding of the links**

Whilst the co-occurrence of IPA, PTSD symptoms and substance use are common, suggesting a clear link, the relationships are often varied and complicated, with differing causal pathways and temporal sequencing. Some of the more common theoretical explanations to explain the links between PTSD symptoms and substance use include:

1) The *self-medication hypothesis* (Khantzian, 1997), whereby PTSD precedes substance use as individuals use substances to lessen the effects of common PTSD symptoms such as hyper-arousal (e.g., use of a depressant in order to calm down) and numbing (e.g., use of stimulants to feel something). Research supporting this theory draws on longitudinal studies with young adults that found exposure to trauma predicted drug use and dependence in those with PTSD (Breslau, Davis & Schulz 2003; Swendsen et al., 2010, Reed, Anthony & Breslau, 2007). In a prospective longitudinal study of 988 adults initially assessed in childhood, after adjusting for childhood factors such as conduct problems, PTSD (not trauma exposure) was associated with vastly increased risk for new onset drug problems one year later (Adjusted risk ratio 4.9, 95%CI 1.6-15.2) (Reed et al., 2007). A random sample of 801 mothers also found that PTSD signalled increased risks of first onset alcohol use disorder (Hazard ratio 3.0, 95%CI 1.7-5.6) (Breslau, Davis, Peterson, & Schultz, 1997). Other researchers have shown that the link between experiencing intimate partner violence and the subsequent development of substance use problems, only existed in the presence of PTSD symptoms (Breslau et al., 2003; Sullivan & Holt, 2008). A study by Sullivan and colleagues found that intimate partner violence was not independently related to reports of drug or alcohol problems. However, higher levels of physical and psychological abuse were related to an increased risk of PTSD, and high PTSD levels were related to higher risk of drug-related problems, but not alcohol use (Sullivan & Holt, 2008). Furthermore, other study participants have reported more vivid and frequent trauma memories after stopping substance use (Reynolds et al., 2005) and correlations exist between PTSD symptoms of hyper-vigilance,

emotional numbing and nightmares, and next day cravings for alcohol (Simpson, Stappenbeck, Varra, Moore, & Kaysen, 2012).

2) The *emotional regulation model* is an extension of the self-medication model and posits that substance use is triggered by many different forms of distress among people with PTSD (e.g., relationship conflict, physical illness) not only the PTSD symptoms themselves (Kramer, Polusny, Arbisi, & Krueger, 2014). Some research has shown that those with dual experiences of SUD and PTSD were more likely to report relapse as a response to negative situations compared to those with single issue SUD (Ouimette, Coolhart, Funderbunk, Wade, & Brown, 2007). Moreover, other studies have found that poor capacity for emotional regulation is associated with PTSD and SUD (McDermott et al., 2009) and has been found to mediate impulsivity in people with SUD and PTSD (Weis et al 2013). Women with experiences of PTSD also frequently report co-occurring depression (Nishith, Nixon & Resick, 2005; O'Campo et al., 2006; Resick, Nishith, Weaver, Astin, & Feuer, 2002), suggesting that where substance use occurs, it may be used for medicating wider symptoms of trauma, not just PTSD.

3) The *high risk and susceptibility model* posits that substance use and associated activities increase the chances of trauma exposure, thereby increasing the risk of developing PTSD (Chilcoat & Breslau, 1998). However, a longitudinal study testing for causal pathways between substance use and PTSD, using a random sample of 1,007 young adults surveyed over a 5-year period, found no evidence for this model (Chilcoat & Breslau, 1998). Other studies exploring IPA exclusively (not PTSD) and substance use suggest bi-directional associations, which may vary by substance. A longitudinal study of a national probability sample of 3,003 women found that a woman's use of drugs (with and without alcohol, but not alcohol exclusively) was associated with increased odds of experiencing a violent assault in the preceding two years, and then experiencing this assault increased her odds once again of using drugs in the same time period (Kilpatrick, Acierno, Resnick, & Saunders, 1997). One study identified that women reporting crack-cocaine or marijuana use were more likely to report intimate partner violence in the subsequent 6 months, compared to non-drug using women (El-Bassel et al., 2005). A study of women with severe mental illness suggested that risks of intimate partner violence among women increase

when substance use co-occurs alongside mental health problems (McPherson, Delva, & Cranford, 2007). This may be because substance use can increase victimisation if women are less able to risk assess and implement safety planning whilst intoxicated (Iverson et al., 2013). However, increased intimate partner violence among women who use substances may also be mediated, in part, by their partner's reports of substance use. One study found that once the abusive partners' substance use was accounted for, women's drug use was no longer associated with any significant risk of victimization (Lipsky, Caetano, Field, & Larkin, 2005).

In addition, various biological and genetic causal pathways have been posited. Low cortisol response soon after trauma exposure may contribute to a vulnerability for PTSD (Yehuda, 2002), and substance use affects the body's stress response system resulting in more blunted cortisol production (Stewart & Conrod, 2003). Others have posited that underlying genetic susceptibilities may influence development of PTSD, SUDs or both (Kramer, Polusny, Arbisi, & Krueger, 2014). Because not all people who have PTSD develop SUDs, researchers have turned to exploring whether distinct disorders such as PTSD and SUDs can be better conceptualised as pertaining to higher-level broader liability dimensions labelled as internalising (directing distress inwards) versus externalising (directing distress outwards). In such cases, PTSD emerges as a result of a shared genetic susceptibility to the internalising dimension and SUDs most commonly resulting from a susceptibility to the externalising dimension. These broad higher-level liability dimensions also correlate to personality traits: internalising linked to negative emotionality and externalising linked to both emotional negativity and disinhibition. Therefore trauma-exposed individuals characterised by both high emotional negativity and high disinhibition are expected to exhibit higher rates of SUDs than individuals characterised only by negative emotionality and the associated propensity toward developing internalising disorders (Kramer et al., 2014). Whilst such modelling can help tune more explanatory models for how PTSD and substance use come to exist within different individuals, it lends itself less well to suggesting treatment interventions among the target group in this PhD study.



## 1.4 The need for gender-responsive treatment

The high levels of co-morbid psychiatric and physical health problems associated with experiences of IPA and PTSD (Reynolds et al 2005; Schafer et al. 2014; Tirado et al., 2018) bring added complexity in attempts to treat substance use. For example, research has highlighted how mental health problems impact on alcohol relapse and treatment outcomes among women with histories of sexual abuse (Greenfield et al., 2002). The implications of this evidence base are that survivors of IPA may require more tailored treatment approaches, which address the co-occurring issue of substance use and mental health in relation to their experiences of trauma, rather than dealing with each issue in silo. As such, calls for gender-responsive substance use treatment, which addresses the ubiquity of women's experiences of IPA, have been growing in the UK and internationally for the past two decades (Galvani, 2009; Grella, 2007; Holly & Horvath, 2012; Humphreys, Regan, River, & Thiara, 2005; Marsh, D'Aunno & Smith, 2000; Simpson & McNulty, 2008). A recent mapping of services for women facing multiple forms of disadvantage such as substance use, mental health and homelessness in England and Wales, identified that just under half of local authorities in England provided any form of gender-specific substance use services for women (Agenda & Against Violence and Abuse, 2017);<sup>3</sup> the most common being weekly women-only groups within gender-specific service (34%) and/or employment of substance use midwives (34%). The report identified nine residential and ten community based comprehensive women-only substance use services, two of which were in London.

More recently in the UK, advocates have been calling for services that are not only gender-responsive, but 'trauma-informed,' in order address IPA and substance use among women (Agenda and Against Violence and Abuse 2017; Prestige, 2014; Sweeney, Clement, Filson, & Kennedy, 2016). This follows developments in the USA, where TIP has been promoted by practitioners for decades (Capezza & Najavits, 2005; Markoff, Fallot, Reed, Elliott & Bjelajac, 2005), and more recently, supported by government guidelines (SAHMSA, 2014). TIP means

---

<sup>3</sup> The data comprised 811 freedom of information requests, 102 survey responses from service providers, and internet research

instigating practice at an organisational level, as well as an individual/clinician level centred around five core principles: trauma awareness, safety, trustworthiness, choice and collaboration, and building of strength and skills (Harris & Fallot, 2001) (See Appendix 1). Within the context of substance use treatment, TIP assumes IPA experiences are widespread and provides practitioners with a framework to avoid re-traumatisation, promote physical safety and use strengths-based practice such as motivational interviewing. This present-focused approach does not require trauma disclosure nor rely on PTSD diagnoses (Fallot & Harris, 2002; Markoff et al., 2005). The revision of UK clinical guidelines for the treatment of substance use have identified TIP as essential practice (DoH, 2017), although the literature is lacking about how such practice is shaping-up within UK substance use services, with only one published study focused on residential women-only service (Tompkins & Neale, 2016). However, the promotion of TIP has gained more traction to date within the UK Criminal Justice System (CJS), much needed due to the high levels of IPA histories among women offenders, as well as co-occurring substance use and mental health problems, resulting in severe levels of self-harm and attempted suicide by women in prison (Light, Grant & Hopkins, 2013; Prison Reform Trust, 2014; Walker, Shaw, Turpin, Reid, & Abel, 2017). In attempts to improve institutional responses, the One Small Thing Initiative<sup>4</sup>, a philanthropic endeavour to roll-out TIP in UK women's prisons, has funded the provision of training, by Stephanie Covington, a leading advocate of TIP in the American CJS. The initiative is now working in 12 women's prisons; and a commitment to developing TIP features in the recently published Women Offenders Strategy (Ministry of Justice, 2018).

Complimenting this wider systems approach of TIP are *trauma-specific services* which are focused on treating trauma through therapeutic interventions delivered by practitioners trained in PTSD. However, there are different schools of thought as to the sequencing of such treatments. A sequential model would see the substance use problem targeted first by the respective treatment provider before a referral is made to a specialist mental health service in order to address trauma experiences. This model was supported by the UK National Institute for Health

---

4 [www.onesmallthing.org.uk](http://www.onesmallthing.org.uk)

and Care Excellence (NICE) 2005 guidance in the treatment of PTSD, which may explain the limited integrated treatment approaches to address co-occurring PTSD and substance use currently available within the UK health care system. The rationale behind this approach was the concern that substance use may increase when undergoing trauma treatments, due to the emotional intensity involved when starting treatment. However, challenges remain as to how best support clients whose PTSD worsens when reducing substances and who may be self-medicating ongoing IPA (Reynolds et al., 2005; Simpson et al., 2012).

A parallel treatment model sees the two conditions targeted by professionals in their respective treatment systems at the same time. In the UK, this approach is similar to how substance use is managed among people with severe mental illness such as psychosis, usually led by a care coordinator within the mental health system, under the Care Programme Approach (NICE, 2016). More recent NICE guidance recommends that those with substance use are not excluded from PTSD treatments (2018) suggesting support for a parallel model. In contrast, an integrated approach uses a framework that acknowledges the link between both PTSD symptoms and substance use and involves the provision of CBT and other therapy modalities to address the symptoms of these conditions concurrently in one 'intervention'. Such models lend themselves well to the self-medication and emotional stress-regulation models, underpinned by an understanding that someone may not be able to reduce substance use or successfully complete treatment until aspects of their PTSD symptoms, and wider stressors such as ongoing IPA, are addressed (Galvani & Humphries, 2007; Swan, Farber & Campbell, 2001).

In Australia and the USA, clinical PTSD guidelines recommend integrated *trauma-specific* interventions (Australian Government, 2013; US Veterans Health Administration, 2017). This may have been driven by the conduct of several randomised controlled trials (RCTs) in the two countries (Roberts, Robert, Jones & Bisson, 2016). Such integrated interventions can be categorised as either '*present*' or '*past-focused*' interventions (Najavits & Hien, 2013). In the context of addressing both PTSD symptoms and substance use, *present-focused* interventions typically focus on establishing both physical safety and stabilisation of trauma symptoms and substance use; and involve psycho-education about the impacts of trauma and links to substance

use as well as the teaching coping skills to manage PTSD symptoms, emotional regulation, and substance use triggers. In past-focused interventions, the active therapy component involves revisiting the trauma memories in detail and typically follows preparation sessions involving techniques taught in present-focused interventions. These are usually delivered by qualified psychologists, following a clinician-led assessment of PTSD.

In addition, new research on the neurobiological and physiological impacts of trauma have brought alternative treatment approaches to the fore-front in recent years (Van der Kolk, 2014; Levine, 2010). These treatments cite the importance of attending to non-verbal regulation techniques, which are different to the cognitive and emotional processing techniques found in most evidenced based PTSD treatments (Levine, 2010; Ogden & Minton 2000; van der Kolk, 2014). 'Top-down' regulation such as mindfulness meditation and yoga strengthen the capacity of the rationale brain (e.g., pre-frontal-cortex) to monitor the body's sensations. 'Bottom-up' regulation involves calibrating the body's 'emotional brain' (e.g. limbic system) through body-orientated activities such as breathing, movement, or touch (Price, Wells, Donovan, & Rue, 2012; Reddy, Dick, Gerber, & Mitchell, 2014; van der Kolk, 2014).

A number of systematic reviews have been published assessing the effectiveness of integrated trauma-specific interventions treating PTSD symptoms and substance use, comprising both past- and present-focused interventions (Fowler & Faulkner, 2011; Roberts et al., 2016; Torchalla, Nosen, Rostam, & Allen, 2012; van Dam, Vedel, Ehling, & Emmelkamp, 2012). The most recent systematic review, comparing psychological interventions for those dually diagnosed with both PTSD and SUDs to a control group, concluded that the most promising outcomes for both issues were found in treatments that included a past-focused element, but only when accompanied by numerous services focused on safety and stabilisation (Roberts et al., 2016). However, the review was unable to provide sub-group analysis by gender due to lack of data, and it was unclear how women experiencing ongoing IPA fared. The gaps in the literature, and more details of the different integrated treatment models for women, are discussed further in Chapter 3.

The PhD study has developed in response to the high prevalence of co-occurring IPA, PTSD symptoms, and substance use experienced by women, and the lack of integrated treatment responses currently available in England, as well as limited gender-responsive treatment, including TIP. The next chapter discusses how the PhD aims to respond to these issues, outlining the aims, objectives, and the four distinct study phases.

## **Chapter 2: Study Outline**

This chapter provides an introduction to the PhD study and its four phases; it details the formulation of the mixed methods design, along with the research paradigms and theoretical frameworks informing the methodology. Figure 3, found towards the end of the chapter, illustrates how all the study phases interact. More detailed methods for each of the study phases are described within the subsequent chapters.

### **2.1 Study aim and objectives**

#### **2.1.1 Overall study aim**

To use mixed-methods to evaluate the feasibility and acceptability of delivering an evidenced-based intervention to support women with experiences of IPA, PTSD symptoms, and substance use, within an English substance use treatment setting.

#### **2.1.2 Study Objectives**

- 1) To conduct a systematic review to evaluate the mechanisms of impact and contextual factors of integrated trauma-specific interventions in reducing PTSD and substance use among women with experiences of IPA, which may inform their successful implementation in an English substance use treatment setting (Phase 1).
- 2) To qualitatively explore English and US stakeholder experiences of delivering interventions to women with experiences of IPA, PTSD symptoms, and substance use; describing their practice models, active programme ingredients, challenges, and wider contextual and implementation considerations (Phase 2).
- 3) To use findings from Phases 1 and 2 to select an evidenced-based integrated trauma-specific intervention and collaborate with services users and practitioners to review and adapt material as needed for the English context (Phase 3).

4) To assess the feasibility and acceptability of delivering and evaluating the adapted version of the chosen intervention, in a group-work format, within an English substance use treatment setting (Phase 4), specifically:

4i. To evaluate the following feasibility parameters: the ability to recruit the target population (i.e., women receiving treatment for substance use with a history of IPA) and retain participants in the group intervention, assess follow-up rates for data collection, and explore how these could be enhanced;

4ii. To assess the required training and supervision needed to support facilitators to deliver the intervention with fidelity;

4iii. To qualitatively explore the suitability and acceptability of administering a variety of measures relating to women's experience of IPA and safety, substance use, and mental health;

4vi. To identify wider contextual factors, and the nature and quantity of wrap-around services provided to women participating in the intervention, that may enhance or detract from effective intervention delivery and positive treatment outcomes.

5) To explore the acceptability, perceived value, helpfulness, harms and unintended consequences of the intervention amongst women attending, and professionals delivering, the intervention; assessed through focus groups, semi-structured interviews, and quantitative data as appropriate;

6) To undertake exploratory analysis of within-group change in substance use, PTSD symptoms, depression, self-esteem, trauma cognitions, emotional regulation, and coping skills immediately at end of the intervention and 3-months post-intervention, assessing for direction of travel, variances, and 95% confidence intervals;

7) To undertake exploratory analysis of data collected by the PTSD measure (PCL-5), to explore the numbers of women experiencing clinically meaningful change as measured by a minimum threshold of 10-point change in the PCL-5 (Weathers et al., 2013).

## **2.2 Rationale and study phases**

### **2.2.1 Phase 1: A narrative systematic review (Chapter 3)**

The first phase of the PhD study synthesises and builds on the existing evidence base for integrated trauma-specific interventions and involves a systematic literature review to explore which integrated trauma-specific interventions work to reduce PTSD symptoms and substance use for which groups of women (subgroups), how (mechanisms of action), and/or under what contexts (factors external to the intervention) (Bailey, Trevillion & Gilchrist, in press).

### **2.2.2 Phase 2: Stakeholder consultation (Chapter 4)**

In the context of limited trauma-informed practice (TIP) in England, the second phase of the PhD study involved a qualitative study of stakeholder experiences from England and the US. First, this explored, in-depth, how services from a range of sectors and clinical disciplines in England have developed models of care for women experiencing the overlapping issues of IPA, PTSD symptoms, and substance use. Secondly, the interviews explored the lessons learnt from stakeholders in the US delivering, or evaluating, integrated present-focused trauma-specific interventions, with a focus on contextual and implementation factors, and their relevance to an English setting. This informed the selection of the evidenced based intervention, the English treatment setting and wider service environment (Phase 3), and the study methodology for the feasibility study which took place in the final stage of the PhD (Phase 4). The results of this initial qualitative study are reported in their own right and also considered in the discussion.

### **2.2.3 Phase 3: Intervention adaptation and implementation considerations (Chapter 5)**

Informed by the learning from phase 2, this phase employed the Theory of Behaviour Change (Michie, van Stralen, & West, 2011) to review the programme content and material of the chosen intervention, adapt as necessary, and plan the various delivery mechanisms in the feasibility study. This phase also involved the collaboration with service staff, and service users with lived experience of IPA and substance use, to select the topics, adapt the participant hand-outs, and



decide on additional new content. 'Public and Patient Involvement' is now a firmly established tenant of research within health and social services, acknowledged from a rights perspective and also for the improvement it brings to research quality (NIHR and INVOLVE, 2018). Service user co-production is also a key part of organisational TIP (Markoff et al., 2005).

#### **2.2.4 Phase 4: Feasibility study (Chapters 6-8)**

There are diverse opinions about the definition of feasibility studies (Arain, Campbell, Cooper, & Lancaster, 2010; Craig et al., 2008; Eldridge et al., 2016; Leon, Davis, & Kraemer, 2011). This study adopts the definition proposed by Eldridge and colleagues (2016), which they based on consultation with a wide range of stakeholders and a systematic review. Within their proposed definition (Figure 1) a 'feasibility study' is an umbrella term for various types of studies that aim to answer uncertainties in preparation for future research involving the eventual conduct of a RCT. A feasibility study asks whether something can be done, should we proceed with it, and if so, how? A number of different types of feasibility study may be conducted to inform decisions about a future RCT, which include randomised pilots as well as purely qualitative research such as consultation with practitioners. The key unifying feature of any of these feasibility studies is that they are answering questions to inform future evaluative research.

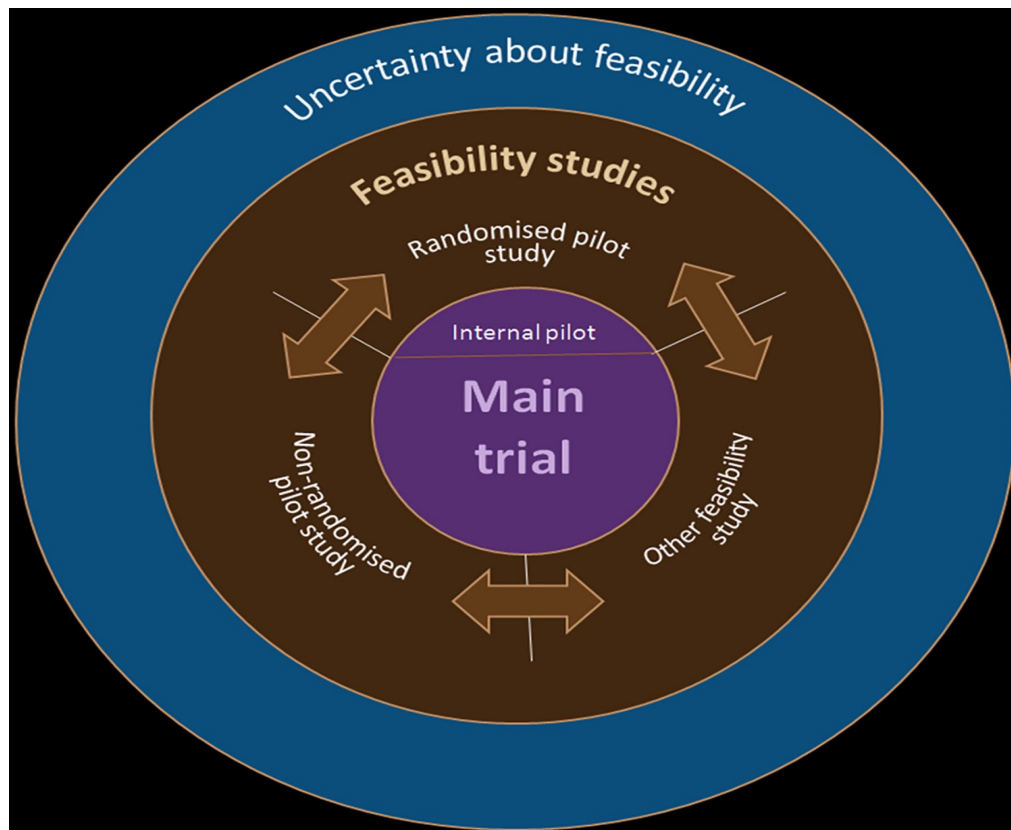


Figure 1: Conceptual framework for feasibility studies  
(Eldridge et al., 2016)

This PhD study explores key uncertainties about the feasibility of delivering an evidenced-based intervention developed in another country, within routine substance use treatment practice in England. In comparison to the USA, England has differing health care provision, treatment philosophies and language related to substance use recovery, combined with limited awareness of TIP and trauma-specific treatments. In particular, the specific uncertainties comprised:

- 1) Acceptability of the content of the material in terms of relevance, the suitability of language, treatment philosophy and cultural references, and its delivery format;
- 2) The level of training and supervision required to ensure the facilitators can deliver the intervention with the required fidelity, and acceptability of women to be video-recorded in order to complete adequate fidelity monitoring;
- 3) The ability to recruit sufficient women meeting the proposed eligibility criteria and retain them in the study, given the low numbers of women in treatment in comparison to men

(PHE, 2018) and high drop-out rates experienced in integrated-trauma-specific interventions (Fowler & Faulkner, 2012; Roberts et al., 2016);

- 4) The acceptability of the study measures to the recruited participants, particular in terms of burden and distress, and suitability for capturing the appropriate outcomes.

In addition, there are particular challenges in providing psychological interventions to survivors of recent intimate partner violence, who may not be ready for psychological therapy (Warshaw, Sullivan, & Riviera, 2013). Questions remain as to whether this group can be recruited and retained in a study safely, and the wider service delivery environment required to support this in the UK, where TIP is uncommon.

The study design is guided by the MRC framework for evaluating complex interventions (Craig et al., 2008; Moore et al., 2015). Figure 2 below outlines four key stages to the development and evaluation of complex evaluations, and this study is aligned to the 'Development' and 'Feasibility/piloting' stage.

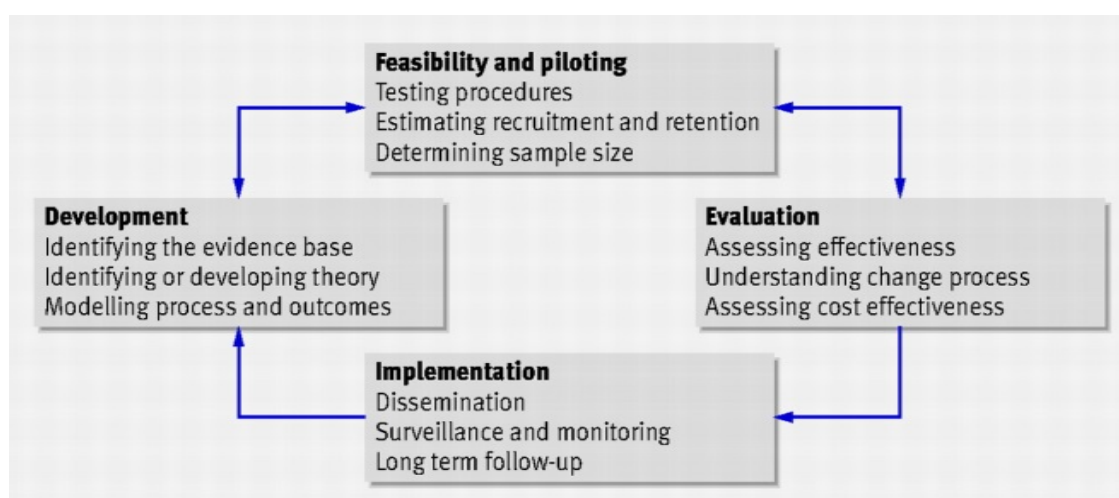


Figure 2: MRC framework for the development and evaluation of complex interventions

The mixed methods design employed in this PhD is highly compatible with this framework (O'Cathain et al., 2015; Moore et al., 2015). Moore and colleagues (2015) recommend the use of qualitative research across various stages. For example, in the early phases of evaluation,

“...a vitally important early task is to develop a theoretical understanding of the likely process of change, by drawing on existing evidence and theory, supplemented if necessary by new primary research, for example interviews with stakeholders” (p.9).

They also highlight the need to draw together various research methods at the stage of feasibility and piloting,

“...a mixture of qualitative and quantitative methods is likely to be needed, for example to understand barriers to participation and to estimate response rates” (p.10).

### **2.2.5 Other research designs**

The uncertainties outlined above were deemed important to answer before proceeding to more costly lengthier research, with larger samples, for example a RCT (Eldridge et al., 2016). Another alternative research design considered was that of Realist Evaluation (Pawson and Tilley, 1997). This approach can also be mixed method in design and provides another alternative to the RCT to explore programme theory for complex evaluations in order to answer questions about how an intervention may be working, or not, and for whom (Pawson and Tilley, 1997). However, this approach is predicated on there already being an established intervention to examine, and sufficient participants with which to undertake data collection (Pawson and Tilley, 1997). Therefore, given the limited trauma-specific work currently taking place across England, this was ruled out as a viable research design. However, the systematic review (Phase 1, Chapter 3) and consultation with stakeholders (Phase 2, Chapter 4) drew on principles from this approach.

## **2.3 Research paradigms and mixed methods design**

The epistemology driving the methodology for this PhD is ‘critical realism’ (Bhaskar 1989). From an ontological perspective, a realist approach accepts an entity can exist independently of our knowledge of it, but that social reality is complex and multi-faceted and cannot be fully understood without exploration of human understanding and interpretation of this reality, which in turn is impacted by social contexts, time, and places (Bryman, 2012; Ritchie, Lewis, McNaughton Nicholls, & Ormston, 2014). As Bryman asserts,

“Social phenomenon are produced by mechanisms that are real, but that are not directly accessible to observation and are discernable only by their effects.” (Bryman, 2012, p. 616)

An example of this research paradigm applied to this study is the proposal that there are ‘active ingredients’ in group-work interventions that support recovery from PTSD and substance use. These ‘realities’ are observed by the effects they have on behaviour. Another example would be the concepts of PTSD and Depression, the presence or absence of which are determined by validated tools reliant on self-reported symptoms by the individuals who experience them. When mixing qualitative and quantitative methods, one is faced with the philosophical challenge of reconciling methods that traditionally espouse opposing ontological and epistemological positions regarding the nature of reality and how we come to learn about that reality (Morgan, 2007). In crude terms, social inquiry involving the collection of quantitative data are typically construed as positivist; that is to say, reality can be known directly, though objective, ‘value-free’ inquiry, based on careful observation using deductive reasoning (Willis, 2007). On the other hand, social inquiry using qualitative data conceives that knowledge is based on interpretations and meanings, facts and values are not distinct, and there is no ‘accurate’ social reality because of the competing interpretations (Bryman, 2012; Willis, 2007). Social constructivists go further and assume all knowledge is socially constructed (Blaikie, 2007).

Supporters of mixed methods design sometimes urge a ‘pragmatic’ approach to the combination of qualitative and quantitative methods based on these opposing ontological and epistemological positions (Creswell & Plano-Clark, 2011; Ritchie et al., 2014). One such pragmatic approach is to conceive a ‘third paradigm’ (Tashakkori & Teddlie, 2010), exploiting the strengths of quantitative and qualitative paradigms within one research design. However, other researchers have argued a different approach that attempts to dismantle the false dichotomy which implies the,

“...strategic or naïve attribution of two distinct sets of qualities to the two large families of methods.” (Bergman, 2008, p.14).

With this approach, different research methods are not necessarily tied to a specific ontological or epistemological position and are more ‘free-floating’ than often supposed (Bryman, 2012, p.

619). For example, a Likert scale or a survey, traditionally the domain of quantitative research methods, can also be used to assess meanings, something usually the domain of qualitative research. In qualitative research, whilst efforts should always be taken to report minority views or deviant cases, themes are often constructed based on the frequent coding of a 'phenomenon' captured by the data. Furthermore, not all statistical analyses involve hypothesis testing within a generalizable and representative data set. Equally, qualitative research can explore hypotheses previously identified in quantitative studies.

With this in mind, this PhD study focuses on explicitly embedding and justifying the choice of research methods, including the analyses, to reflect the research question. The decision to employ a particular research tool, whether it be a structured questionnaire or semi-structured interview, does not necessarily align the researcher to a particular epistemological or ontological standpoint (Bergman, 2008; Bryman, 2012). Adopting Bryman's classifications (Bryman, 2016), Table 1 illustrates some of the expected ways the methods may be mixed, or 'interface' across each phase of the study. Whilst some points of interface can be determined a priori, others (e.g., triangulation) may only follow once the data is collected (Bryman, 2016). As such, the study will allow flexibility for mixing of data in ways that are not fully anticipated in advance.

Table 1: The mixing of methods across the different phases of the PhD

Phase	Type of research	How methods were mixed (Bryman, 2016)
Phase 1	Narrative Systematic Review	<b>Triangulation:</b> Quantitative and qualitative data extracted from the articles were combined for corroboration.
Phase 2	Stakeholder Consultation	<b>Development:</b> Results of this qualitative study were used to inform phase 3 & 4 including methodology decisions regarding choice of measures.
Phase 4	Feasibility Study	<b>Completeness:</b> Qualitative and quantitative data is used to provide a more comprehensive account of the research questions, e.g., acceptability of the intervention; retention rates alone are not sufficient to ascertain acceptability, and the

		<p>reasons for non-attendance may be varied and best captured in qualitative data.</p> <p><b>Explanation:</b> Qualitative data is used to explain some of the outcomes data e.g., participants' understandings of why the changes may have come about.</p> <p><b>Context:</b> Qualitative data provides wider contextual explanations coupled with more generalizable quantitative measures e.g., service environment and number of wrap-around services.</p> <p><b>Confirm and discover:</b> Qualitative data is used to form hypotheses, which are then confirmed or denied in the quantitative data.</p> <p><b>Triangulation:</b> Quantitative and qualitative data were combined for corroboration.</p>
--	--	---

Thematic analysis, used to analyse the qualitative data in this study across phases, is a flexible tool consisting of a broad umbrella of different approaches, which can contain both positivist, as well as interpretivist/constructionist, approaches to social inquiry (Bryman, 2012). At its core, it is a method for detecting, analysing, and reporting patterns ('themes') in the data (Braun & Clarke, 2007), allowing for both inductive and deductive approaches (Fereday & Muir-Cochrane, 2006). Other analytic approaches also look for patterns but are more theoretically driven. For example, grounded theory searches to establish theories based on the data and attempts to be purely inductive in the analysis.

Figure 3, adapted from Creswell and Plano-Clark (2007), outlines how phase 1 & 2 of the study inform phases 3 & 4 in a sequential manner. The feasibility study (Phase 4) comprises a *concurrent* mixed method design whereby quantitative (QUANT) and qualitative (QUAL) data are collected and analysed together. Interpretation of the feasibility study forms the final discussion chapter and draws on the findings from the previous phases. More details regarding the mixed methods analysis for the feasibility study are provided in Chapter 6.

As a final note, I adopt a mixture of first-and-third person narrative throughout the chapters to reflect the fluidity between the epistemological assumptions underpinning the different research

tools (Zhou & Hall, 2016). This attempts to bring a more intimate perspective to the more distant and 'objective' third person narrative.



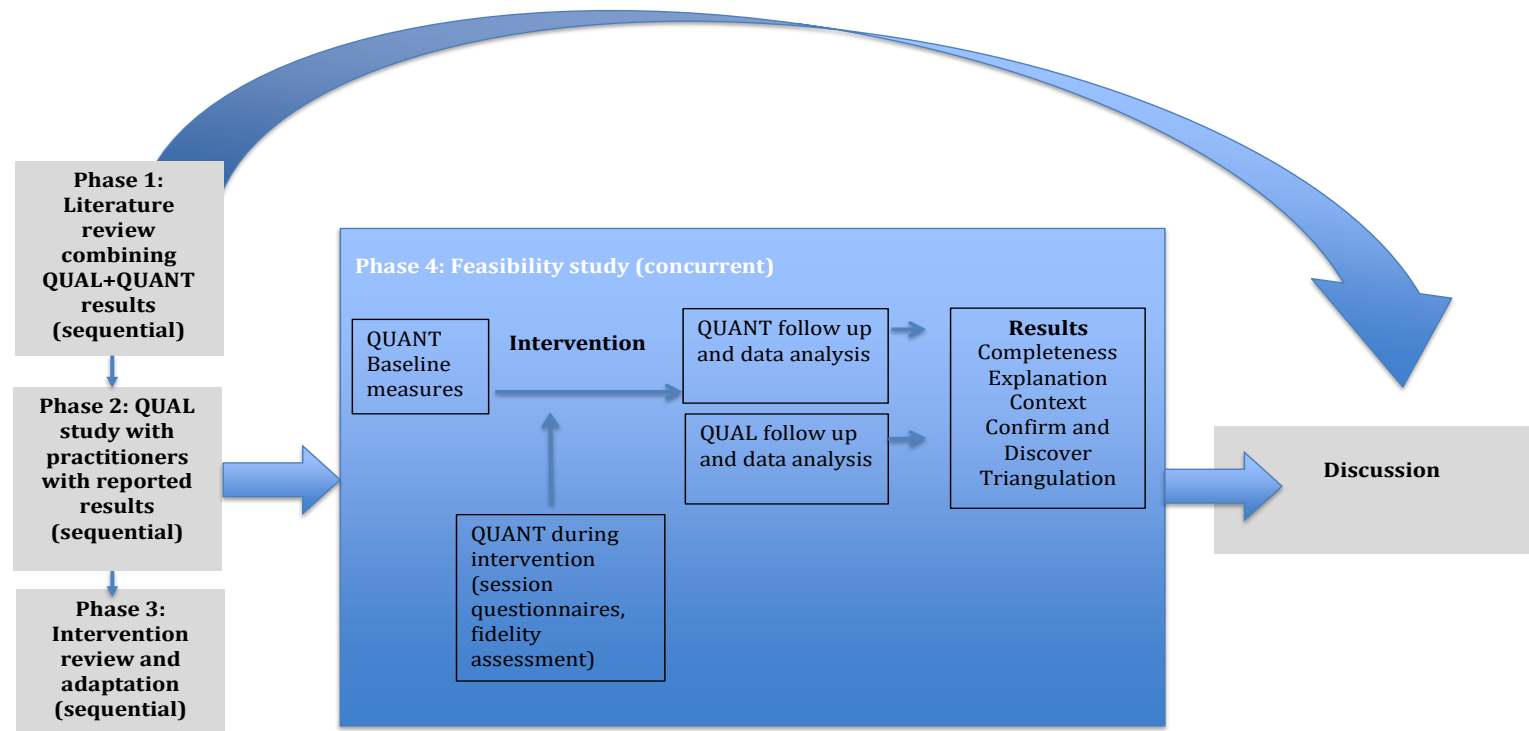


Figure 3: Flowchart of study phases using mixed methods quantitative (QUANT) and qualitative (QUAL)

## 2.4 Theoretical frameworks influencing the study

### 2.4.1 Social-ecological model for violence against women

The aetiology and risk factors for victimisation and perpetration of violence against women can be understood in terms of the social-ecological model devised by Heise (1998) and adapted in Figure 4. It encompasses a feminist understanding e.g., societal structures grant men a sense of entitlement in their behaviour towards women. It also acknowledges the contribution of individual and situational factors faced by victims and perpetrators such as childhood trauma, substance use and poverty, which interact with community and societal structures over the course of a lifetime (Etherington & Baker, 2017).

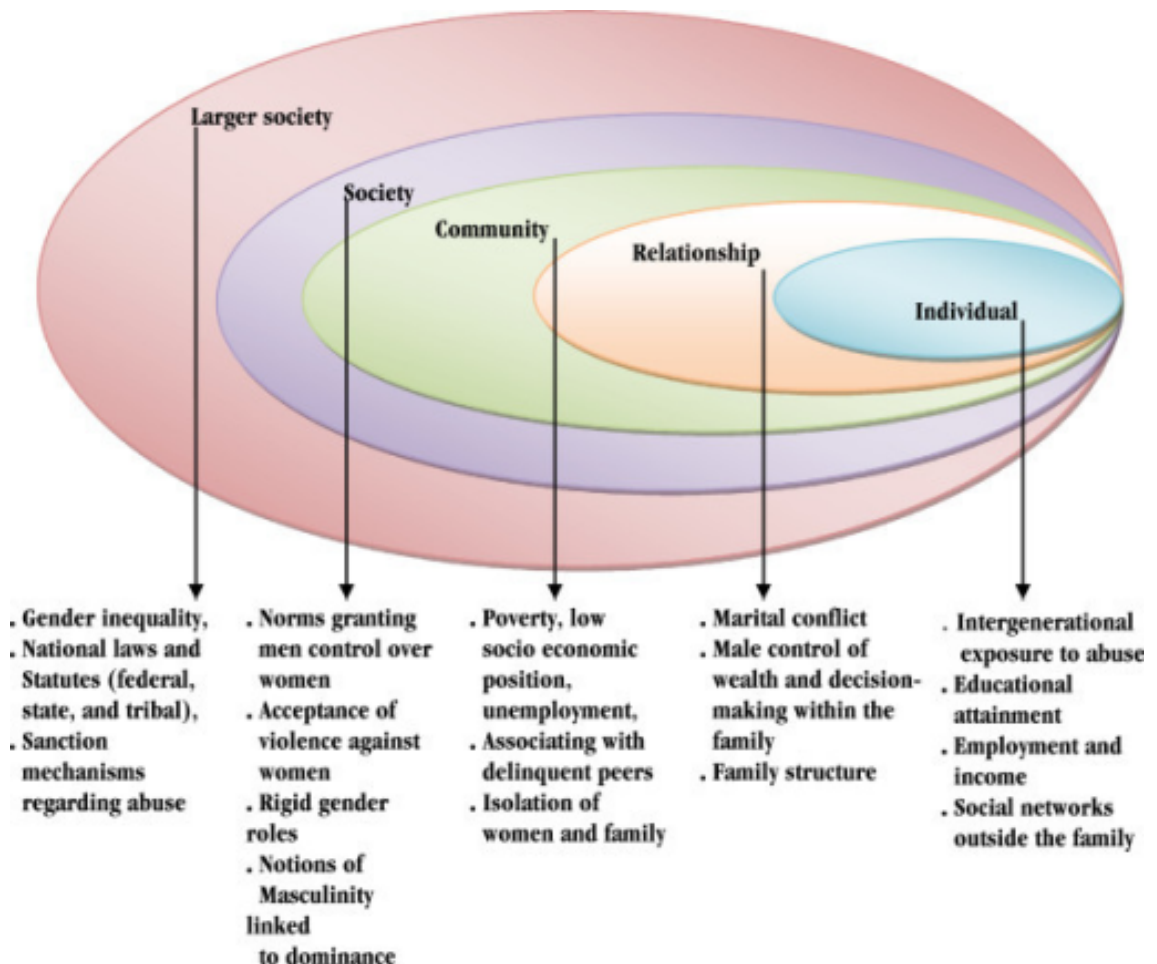


Figure 4: Socio-ecological model of violence against women (adapted from Heise, 1998)

### **2.4.2 Staged model for the treatment of Complex PTSD**

There is general agreement among clinicians that a multi-component, phased treatment model is most suitable for people who have experienced prolonged and repeated trauma of an interpersonal nature (Cloitre et al., 2011; Herman, 2001; Rothschild, 2011). Current UK guidelines (NICE, 2018) state that staged treatment is required for more complex cases, such as Complex PTSD, and particularly where the threat is ongoing. This model can be summarised as such: 1) establishing physical safety and building collaborative therapeutic relationships; 2) managing symptoms and emotional regulation; 3) disclosure by exploring traumatic memories in-depth (e.g., exposure interventions); and 4) reconnection with both the self and others (Herman, 2001). The staged model does not necessarily move in a linear fashion, there may be movement back and forth between stages.

### **2.4.3 The COM-B theory of behaviour change**

The COM-B theory of behaviour change outlined by Michie, Atkins, & West (2014), theorises that changing any behaviour involves changing one or more of the following: *capability*, *opportunities*, and *motivation* relating to the behaviour itself or behaviours that compete against or support it. Capabilities (psychological/physical) and Motivation (automatic/reflective) are most often concerned with changing an individual's behaviour, whilst the domain of Opportunities (social/physical) requires consideration of the wider contextual environment that may promote or inhibit an individual's behaviour. This theory draws on a detailed list of "taxonomy of behaviour change techniques" developed by expert consensus (Michie et al., 2014), which can be used to design an intervention or map key behavior change techniques inherent in an existing intervention. This theory was used to inform the review and implementation of the integrated trauma-specific intervention forming phase 3 of the study and discussed further in Chapter 5.

## **2.5 Researcher reflexivity and standpoint**

I believe that knowledge claims about the impact of health research, for example, "does this treatment work?" must be set within the social conditions found in the world today and should account for the intersecting influences such as gender, social class, and race. To this end, as a Caucasian, heterosexual woman, I should be conscious of how my positionality in the research

influences the research design, data collection and analysis, and explore steps to mitigate against potential bias. For example, in anticipation of the heterogeneity of the research participants, I have chosen trauma measures which apply a wider definition of trauma than traditionally found in most validated measures, and which ask about discrimination on the basis of race, ethnicity, sexual orientation and disability, as well as aspects of social class such as homelessness. In the stakeholder interviews (Chapter 4), I included questions in the interview topic guide to ask about intersectional approaches (Bograd, 1999) to service delivery, reflecting how many forms of discrimination intersect with gender. One of the study practitioners for the feasibility study was chosen for her culturally informed psychotherapeutic practice. Upon advice from an academic who specialises in research with diverse groups, I included questions in the socio-demographics that capture migration status and first language.

Given the role of power and control in the perpetration of IPA directed towards women,

“Investigators must examine how they support the abuse of power by consciously or unconsciously using privilege, gender, coercion, or intimidation in their approach to participants”  
(Langford, 2000, p.135).

As such, I believe the adoption of research approaches often found in social critical theory are important. For example, feminist research principles that promote the primacy of women’s understandings of their own experiences (Oakley, 1981), and more participatory approaches to research which involve ‘those being researched’ as essential parts of the research for ethical reasons (Higginbottom & Liamputtong, 2015). These approaches attempt to reject differentiations between the researcher and those being researched, typically found in positivist research, and allow the voices of a group of people, who are often stigmatized, to be heard and given equal importance. To this end, in attempt to acknowledge different forms of expertise, I attempt to involve several ‘experts-by-experience’ in the recruitment design and the review of intervention material in phase 3. Whilst I did not have full control over which women would volunteer to take part, the group were diverse in terms of ethnicity, age and sexual orientation, ensuring viewpoints that differed to mine.

I arrive to this PhD study having worked in the domestic and sexual violence sector in England for over a decade and this has shaped my philosophical understandings of IPA against women, mental health and the intersections with other forms of multiple disadvantage faced by women. Working in refuges, interviewing survivors, training staff in substance use treatment services, and facilitating groups with men who have committed IPA, have shaped my world-view. In line with a feminist research standpoint, I acknowledge that there are socio-political and emancipatory ideals driving the choice of my research topic. I have a strong desire to raise awareness of the specific and different treatment needs of women accessing substance use treatment within a system which was designed for a predominantly White male client base. This treatment system also operates within wider societal and institutional structures that can permit IPA against women to continue.

Within this context, I found it a continual challenge to resist adopting my previous professional role when working with the study participants. For example, I found it difficult to limit my interactions with women who asked me for advice about recovering from IPA, beyond the provision of leaflets for support services. I had to resist my internal urge to explain to them why their self-esteem scores may be so low in relation to the abuse they had experienced. I was asked for advice about family court proceedings by one participant who was struggling to keep custody of her new born baby, and internally I was wondering why she was not involved in the family drug court in the borough, which I believed would result in a better outcome. Whilst I informed her about the court and advised her to look this up on the Internet, I also found myself wondering how much I am allowed to say and how much am I overstepping my role as a researcher. I noted these impressions and uncertainties in a reflective diary and raised in clinical supervision sessions. Cartwright and Limandri (1997) discuss a similar dilemma related to the dual role of clinician-researchers asked about health issues by study participants. They argue that it may be a requirement to alternate between these roles when researching vulnerable populations.

The next chapter presents the first phase of the PhD study, a narrative systematic review to further explore the evidence base for integrated trauma-specific interventions aimed at women with IPA histories.

## Chapter 3: Systematic Review

This chapter is an extended version of a journal article due to be published in the Journal of Substance Abuse Treatment in 2019, entitled:

*“What works for whom and why: A narrative systematic review of interventions for reducing post-traumatic stress disorder and problematic substance use among women with experiences of interpersonal abuse.”* (Bailey, Trevillion & Gilchrist, in press)

It incorporates additional literature related to implementation considerations that were excluded in the article.

### 3.1 Introduction

There is mounting evidence that integrating substance use treatment into the PTSD staged model is not only safe, but more effective for people who have co-occurring experiences of PTSD and substance use (hereafter “substance use”) (Najavits & Hien, 2013; Roberts et al., 2016). ‘*Present-focused models*’ focus on first stage safety and stabilisation work to address both PTSD and substance use (e.g. establishing therapeutic relationships and physical safety, psycho-education about the trauma and substance use, coping skills development), sometimes comprising over 30 sessions in trials. ‘*Past-focused models*’ combine this first phase with the second phase of memory processing (exploring traumatic memories in detail); and in trials generally comprise 8-12 sessions.

#### 3.1.1 Justification for the systematic review

To date, systematic reviews considering the effectiveness of these treatments have included samples of men and women with a wide range of traumas. Some contained a narrow focus on randomized controlled trials (RCTs) involving participants with PTSD and Substance Use Disorder (SUD) (Roberts et al. 2016), others included quasi-experimental trials with looser participant inclusion criteria regarding PTSD and SUD (Fowler & Faulkner, 2011; Torchalla et al., 2012; van Dam et al., 2012). The most recent systematic review, comparing psychological interventions for those dually diagnosed with both PTSD and a SUD to a control group, concluded

that the most promising outcomes for both issues were found in treatments that included a past-focused element, but only when accompanied by numerous services focused on safety and stabilisation (Roberts et al., 2016). However, descriptions of these services were lacking, dropout was high, sub-group analysis by gender unavailable due to lack of data, and their suitability for women facing ongoing victimisation unclear. Evidence suggests that some women receiving these interventions, for example those with acute emotional dysregulation, may require a lengthier focus on coping and safety skills (Cloitre, Koenen, Cohen, & Han, 2002), as well as emphasis on the mind-body connection (Levine, 2010; van der Kolk, 2014). In light of this, increasing attention has been paid to the role of mindfulness-based practices such as meditation and yoga, with trials demonstrating promising results in addressing PTSD (Emerson, 2014; Goldsmith et al., 2014) and substance use (Li et al., 2017). However, evidence on their impact on both issues among women is lacking. Therefore, the task remains to better determine the active ingredients of integrated trauma-specific interventions to address PTSD and substance use among women with IPA histories, and the wider contextual factors impacting implementation to improve and tailor treatment for women.

### **3.1.2 The importance of exploring evidence beyond treatment effect**

Traditional systematic reviews focused on effectiveness typically aggregate quantitative data to answer the question of whether a particular intervention works or not, 'the treatment effect'. However, as Petticrew et al. (2015) argue, this may only be the first stage in a longer process of exploration to determine how something may be working, for whom, and under what circumstances. Moving beyond treatment effect when considering the evidence base avoids obscuring nuanced differences within study populations and treatment conditions. Evaluation of complex interventions also requires exploration of the interactions between the intervention of interest and the contextual factors in which it is implemented, as well as moderators and mediators on the effects of the interaction (Petticrew et al., 2015).

In order to do this, it is necessary to examine a broad range of literature including qualitative and secondary data analyses, practitioner, organizational, and service user knowledge to glean insights as to why a treatment may or may not be working for certain groups and in certain settings (Pawson & Tilley, 1997; Petticrew et al., 2015). Such approaches, often drawing from principles

of realist review (Pawson & Tilley, 1997) are now accepted as sound methodologies to complement more traditional quantitative based meta-analysis and subgroup analysis (Moore et al., 2015; Petticrew et al., 2015).

### **3.1.3 Aim of the systematic review**

In order to synthesise and build on the existing evidence base, this systematic narrative review explored which integrated trauma-specific interventions (hereafter “integrated interventions”) work for which groups of women with co-occurring IPA and varying ranges of substance use and PTSD severity (subgroups); how (mechanisms of action within the interventions), and/or under what contexts (factors external to the intervention).

## **3.2. Methodology**

This review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Moher, Liberati, Tetzlaff, & Altman, 2009) and narrative synthesis guidelines (Popay et al., 2006).

### **3.2.1 Search strategies**

A two-staged search strategy identified eligible studies. Stage one identified controlled trials reporting on the effectiveness of psychological or mindfulness-based interventions for PTSD and substance use. Stage two identified relevant supplementary information [e.g., process evaluations, implementation guidance, and secondary data analyses] related to the trials identified in Stage 1.

#### **3.2.1.1 Stage one**

Multiple searches were conducted for stage one (see Appendix 2 for full list of search terms). These comprised: a) identification of trials contained in eight literature reviews identified in a prior scoping exercise and b) separate electronic searches of bibliographic databases for psychological interventions and mindfulness-based interventions for PTSD and substance use. Medical Education Subject Headings and free text keywords were used to search PsycINFO, Medline, CINAHL, PILOTS, and Clinicaltrials.gov from 01.01.14-08.03.16 for: 1) psychological integrated



interventions published since the most recent review (Roberts, Roberts, Jones, & Bisson, 2015)<sup>5</sup> and 2) mindfulness- based interventions (inception to 01.04.16). Most papers found in stage one were from PsycINFO therefore an update was completed in PsycINFO, Clinicaltrials.gov and PILOTS until 18.04.18.

### **3.2.1.2 Stage two**

Multi-staged searches were also conducted for stage two. Searches involved: a) an electronic search of PsycINFO, MEDLINE, PILOTS and Embase (from inception to 05.10.16) entering the names of the primary studies or interventions, with an update on 19.04.18 in PsycINFO and PILOTS; b) websites searches; c) forwards and backwards citation tracking in the original trials; and d) contact with authors of eligible trials from Stage 1 where little or no supplementary papers had been identified by other means.

### **3.2.2 Selection criteria**

Studies were eligible for inclusion (stage one) if they: a) reported on effectiveness of interventions to concurrently address PTSD and substance use, b) were controlled trials, c) were published in English, d) included samples involving more than 50% of women aged at least 18 years, and e) reported outcomes for both PTSD and substance use. Supplementary information was included (stage two) if they: a) were qualitative studies, process evaluations, implementation guidance, or secondary data analyses from the eligible studies identified in stage one; and b) explored for whom (subgroups), how (mechanisms of impact, mediators), and under what contexts (factors external to the intervention impacting on treatment outcomes) the intervention produced change; and provided information relating to implementation considerations (e.g., programme fidelity, treatment retention, staff qualifications). Dissertations, book chapters and studies limited to non-interpersonal trauma were excluded from both stages.

---

<sup>5</sup> This is an earlier version of the full Cochrane systematic review published in 2016 after this search strategy was implemented. This earlier version included searches running up until 01 Jan 2014 which is the starting point for search 2 in this review. The full review (Roberts et al .2016) comprises a later upper limit search date of 11.03.15.

### 3.2.3 Data extraction

KB assessed all abstracts and potentially eligible full-text manuscripts from stage one against eligibility criteria. GG or KT also independently assessed all abstracts and potentially eligible full-text manuscripts from stage one. Disagreements were resolved through referral to a third reviewer (from GG and KT), however this happened on only a few occasions. KB then extracted the following data from each trial: a) basic study details; b) details of the interventions and control (modality/dosage); c) details of participants (% female, abuse history, ongoing IPA, % with PTSD/SUD; d) study measures, PTSD/SUD outcomes and attrition; and e) details of any subgroup analysis, mechanisms of action and/or context.

### 3.2.4 Quality appraisal

KB assessed eight domains of the trials' methodological quality using the McMaster University Quality Assessment (EPHPP, 1998). GG or KT also independently assessed the methodological quality of the trials. Differences were resolved through referral to a third reviewer (from GG and KT). This quality assessment tool was chosen for its strength in assessing the quality of randomised and non-randomised trials within health settings. The component ratings comprise a) Selection bias; b) Study design and randomisation; c) Confounders; d) Blinding; e) Data collection methods - validity and reliability<sup>6</sup>; f) Withdrawals and drop-outs; g) Intervention integrity; and h) Analyses. Each of the six components A-F are rated as either strong, moderate or weak. The global rating was scored as strong only if no weak ratings were given across the components, moderate if one weak rating was scored, and weak if two or more weak ratings were given across the components.

All supplementary information was assessed by KB using the TAPUPAS standards (Pawson, Boaz, Grayson, Long, & Barnes, 2003): 1) *Transparency – is it open to scrutiny?* 2) *Accuracy – is it well grounded?* 3) *Purposivity- is it fit for purpose?* 4) *Utility – is it fit for purpose?* 5) *Propriety – is it legal and ethical?* 6) *Accessibility – is it intelligible?* 7) *Specificity – does it meet source specific*

---

<sup>6</sup> Assessment tools relating to the main outcomes of interest, PTSD and substance use, were assessed.

*standards?* For this last standard The Critical Appraisal Skills Programme Qualitative Checklist (CASP, 2018) was also used where applicable. This framework encompasses a wide range of data (categorised as research, practitioner, organisational and service user). Trial quality scores and limitations to the supplementary information identified with the TAPUPAS framework informed consideration of the robustness of the final narrative synthesis.

### **3.2.5 Analysis**

A narrative synthesis of the data from searches in stage one and two was conducted (Popay et al., 2006). As the purpose of this review was not to determine treatment effect, meta-analyses were not performed. Instead, synthesis drew on principles of thematic analysis (Fereday & Muir-Cochrane, 2008) primarily driven by a deductive a priori codebook aligned to the research questions but with flexibility to allow identification of new codes identified in the data. All manuscripts identified across the two stages were uploaded NVivo 10 for management of the analysis. All of the manuscripts were read, and relevant chunks of data were assigned or 'coded' into the four broad deductive a priori categories of 'Subgroups', 'Mechanisms of action', 'Context', and 'Other implementation considerations.' Those manuscripts that did not provide information to support these areas remained un-coded. The next stage involved reviewing all the requisite data assigned to each broad code and then further categorising with more inductive codes. After this process, 35 separate sub-codes had been devised, and all the data assigned under the original broad four codes were revisited, and the new sub-codes assigned. Appendix 3 provides details of these sub-codes, for example, the original code of 'Context' included the sub-codes of: *ongoing victimisation, wrap-around services, trauma informed practice, systems, social support networks, service user involvement, case management, gender specific services, and strengths-based practice.*

At this stage it was apparent that there was overlap between codes. For example, *ongoing victimisation* was a sub-code assigned to data original coded to 'Sub-groups' and 'Context'. Therefore, at this point, some codes were merged or re-labelled. These codes were then re-grouped into overarching themes (e.g. 'Wider Organisational approach' embraced the sub-codes of *trauma-informed practice, wrap-around services, and case-management*). Analysis focused on

relationships between the data and PTSD and substance use outcomes in individual trials, and if any of these relationships were reciprocated or refuted across studies. The narrative summary was produced from triangulating corroborative data, pertaining to the over-arching identified themes, spanning both the primary trials and their various supplementary outputs. The majority of data used in the findings involves trials comprising women only. Where data refers to mixed samples this was noted in the findings with attempts to triangulate the data with women only studies.

## **3.3 Results**

### **3.3.1 Study selection**

#### **3.3.1.1 Stage one**

Figure 5 provides the PRISMA flowchart of the two-stage search strategy. A total of 1718 records were generated from the stage one search after removal of duplicates. Following the screening of titles and abstracts, 107 full text manuscripts were assessed against eligibility criteria. Thirty-two manuscripts from 20 trials were included. Twenty manuscripts pertaining to 16 trials were identified through the scoping of the eight literature reviews. Another four manuscripts pertaining to four new trials were identified in the subsequent searches. In total, 24 manuscripts from 20 trials reported on primary outcomes relating to both PTSD and substance use ("primary studies"). Of these, five separate manuscripts resulted from one trial, the Women and Co-occurring Disorders and Violence (WCDV) study, which was delivered over nine sites in the USA, with each site implementing a present-focused integrated intervention from a choice of five different models. One manuscript (see Table 2, 24) includes the multi-site analysis, and a further four manuscripts (see Table 2, items 13, 16, 17, 18) provide analyses of site-specific findings. A further eight manuscripts were secondary data analyses associated with five of the 20 trials.

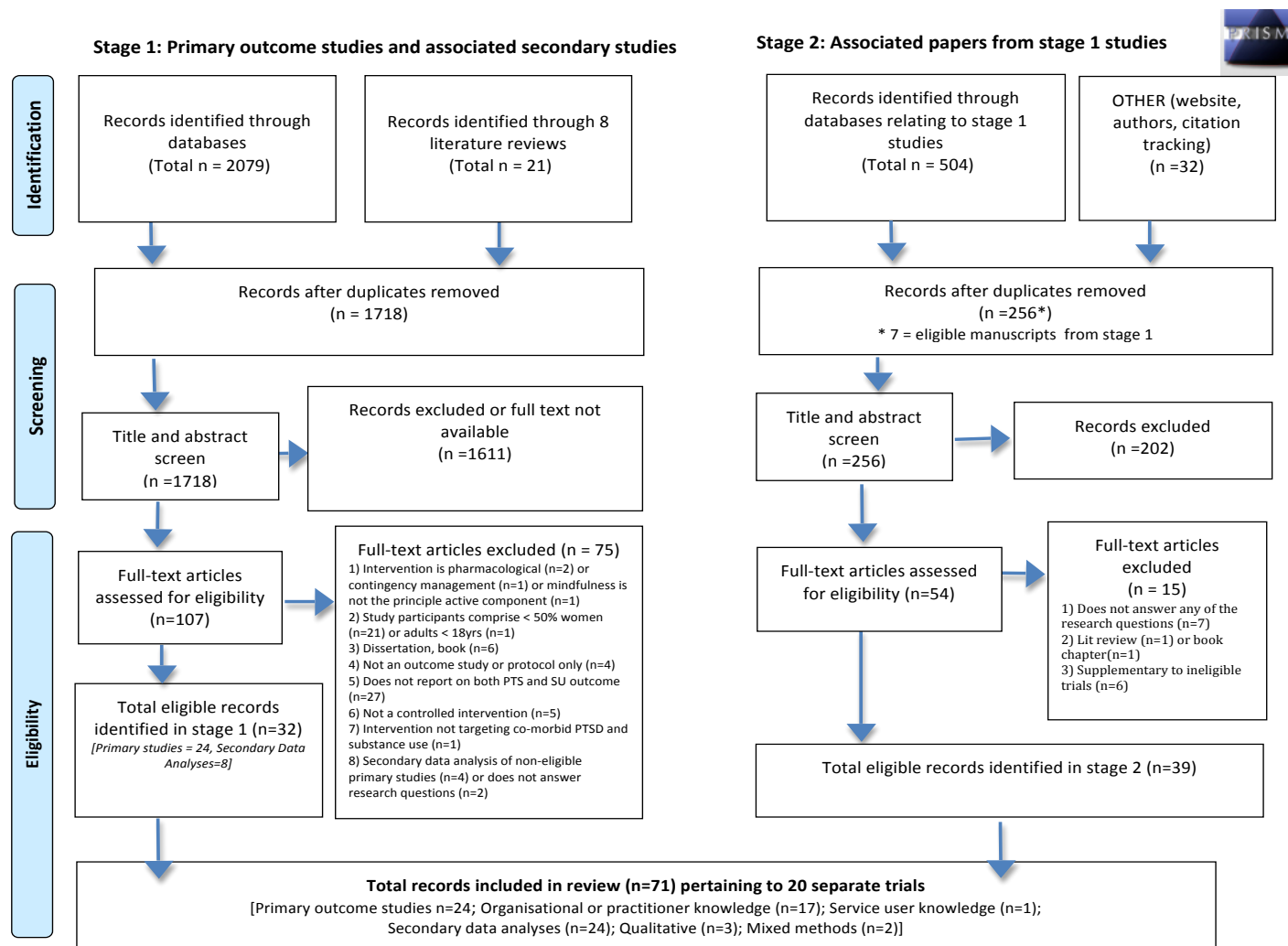


Figure 5: PRISMA Flowchart of two-stage search strategy for the systematic review

### **3.3.1.2 Stage two**

The stage 2 search yielded 256 unique records resulting from the 20 trials identified in stage one; of which 202 were excluded following title and abstract screening. Fifty-four full text manuscripts were screened for eligibility resulting in 38 eligible manuscripts comprising supplementary studies to trials in stage one. Four of these were obtained from the primary trial authors (Calhoun, Messina, Cartier & Torres, 2012; Ford & Russo, 2006; Gilbert, 2006; Mills, Back et al., 2012). Combining the results from stages one and two, there were 71 total records considered in the narrative review. Twenty-four comprised primary studies pertaining to 20 trials, with 47 associated supplementary papers.

### **3.3.2 Sample overview**

#### **3.3.2.1 Primary studies and the treatment models**

An overview of the 24 primary studies and treatment outcomes are presented in Table 2 with their corresponding supplementary papers listed alongside. Appendix 4 provides more detail of the content of all the models used in the trials. The majority of primary studies were conducted in the USA within substance use or mental health treatment agencies targeted at women with any form of substance use.

Nineteen of the studies used *present-focused treatment models*, differing in their balance of components, but typically focused on providing strategies for improved coping skills for both PTSD and substance use, e.g., skills to manage emotional self-regulation and substance use triggers, safety planning, and/or cognitive restructuring to address shame/guilt. They were mostly delivered in group-work ranging in length from 8-48 sessions. Two models dominated, Seeking Safety (Najavits, 2002) and Trauma Recovery and Empowerment Model (TREM) (Harris, 1998). The WCDV multi-site study, a non-randomised controlled study, involved the delivery of a present-focused trauma-specific group-work programme within services implementing wider trauma informed practice and other interventions. The majority of the trauma-specific interventions comprised Seeking Safety or TREM. Morrissey, Jackson et al., (2005) provide a meta-analysis of 12-month outcomes across all nine sites. Three of the WCDVS sites, which

implemented the TREM programme, published their data separately (Amaro et al., 2007; Fallot, McHugo, Harris, & Xie, 2011; Toussaint, VanDeMark, Bornemann, & Graeber, 2007).

Only one study comprised mindfulness as the active core mechanism with body-focused strategies to deal with emotional self-regulation. Mindful Awareness in Body Therapy (MABT) (Price et al., 2012), has markedly different change mechanisms compared to the other present-focused interventions. The active mechanism involves integration of sensory awareness into cognitive processes, designed to facilitate embodied self-awareness (vs dissociation and avoidance) to deal with stress and negative emotions. It is delivered over 8 weeks in individual session by trauma trained massage therapists.

The *past-focused* models typically contained a form of narrative exposure therapy involving the processing of memories from a selected traumatic incident combined with various Cognitive Behavioural Therapy (CBT) components such as cognitive restructuring and motivational interviewing for both substance use and PTSD symptoms. These models were provided on a one-to-one basis and most included 1-4 sessions of safety and stabilisation components before progressing to the exposure components for a further 6-7 sessions. Two studies used prolonged exposure (Mills, Teeson, et al., 2012; Sannibale et al., 2013) originally developed to treat the singular issue of PTSD and involves an imaginal component whereby the service user recounts the episode in detail orally. This is recorded and listened to repeatedly over several sessions with the therapist, and at home by the client.

#### **Key for abbreviations in Table 2**

PTSD = Post-traumatic stress disorder; DESNOS = Disorders of Extreme Stress Not Otherwise Specified; SUD= Substance Use Disorder; AUD=Alcohol Use Disorder; T = Treatment; C=Control; NR = not reported; TAU = Treatment as Usual; F= Female; CSA= Child sexual abuse; CPA=Child physical abuse; ASA= Adult sexual abuse; APA=Adult Physical Abuse; ICBT = Integrated CBT for PTSD and SUD; IAC = Individual Addiction Counselling; COPE = Concurrent Treatment of PTSD and SUD Using Prolonged Exposure. ATRIUM= Addictions and Trauma Recovery Integrated Model; QA=Quality Assurance; S=Strong; M=Moderate; W=Weak.

\* Remaining sample had sub-threshold PTSD. \*\* Within past 6 months, data drawn from Fowler & Faulkner 2011. \*\*\*Interventions sites: trauma informed services, outreach and engagement, screening and assessment, parenting skills training, resource coordination and advocacy, crisis intervention and peer run services. ^Inclusion criteria involved diagnosed mental health disorder in past five years, % with PTSD not reported only average scores for PTSD which indicated an average of moderate to severe for total sample (McHugo et al., 2005).

^^ No separate studies published on WCDV sites which implemented these models.

Table 2: Summary of studies identified in stage one and their associated supplementary studies

	Study design	Setting, Country, Sample size (T/C)	Dosage	Control	F%	IPA	Recent IPA %	PTSD %	SUD (AUD) %	PTS Outcome T> C	SU Outcome T>C	Follow up length	QA	Supplementary studies
	<b>Past Focused Treatments</b>													
	<b>Prolonged Exposure combined with CBT</b>													
1	Mills, Teeson et al., 2012; RCT	Unclear, Australia n=55/48	13 x weekly individual 90 minute of COPE + TAU	TAU	62	Sexual assault 77%; physical assault 96% CSA 46%	NR	100	100	Y	N	9-months from baseline	S	[n=2: Mills, Back et al., 2012; Mills et al., 2016]
2	Sannibale et al., 2013; RCT	Substance use clinics, Australia n=33/29	12 x weekly individual 90-minute sessions of ICBT for PTSD & AUD + homework	CBT for AUD + supportive counselling	53	Violent crime (inc. rape) 31; CPA/CSA 23%; domestic violence 7%	NR	100	(100)	Y <sup>7</sup>	N	9-months from baseline	S	
	<b>Other exposure-based interventions</b>													
3	Coffey et al., 2006; RCT	Laboratory, USA n=16/15	1 education session & 6 x individual trauma focused imaginal exposure + TAU	Imagery relaxation + TAU	67	CSA 82% CPA 50%	NR	100	(100)	Y	Y <sup>8</sup>	Post treatment	W	
4	Triffleman, 2000; RCT	Community substance use treatment, USA n= 9/10	20 x twice weekly individual sessions (Stress Inoculation Therapy and in-vivo exposure) combined with CBT	Twelve Step Facilitation Therapy	70	NR	NR	70*	100 <sup>9</sup>	N	N	1-month from baseline	W	[n=2: Triffleman, Carroll & Kellogg, 1999]

7 Only T participants who did not drop out before receiving the exposure sessions (starting in session 5) had a twofold greater likelihood of clinically significant reduction in PTSD severity at follow up.

8 But this did not meet statistical significance when confined to those reporting alcohol craving to trauma imagery cues.

9 Current or history of SUD.



	Study design	Setting, Country, Sample size (T/C)	Dosage	Control	F%	IPA	Recent IPA %	PTSD %	SUD (AUD) %	PTS Out-come T>C	SU Out-come T>C	Follow up length	QA	Supplementary studies
	<b>Eye Movement Desensitisation and Re-processing (EMDR)</b>													
5	Perez-Dandieu & Tapia, 2014; RCT	Outpatient drug clinic, France n=6/6	8 x individual EMDR sessions (3 in first month, then one monthly) +TAU	TAU	100	Sexual abuse 58%; physical abuse or threats 33%	NR	100	100	Y	N	6-months from baseline	M	
	<b>Present focused treatments</b>													
	<b>Integrated Cognitive Behavioural Therapy for PTSD (ICBT)</b>													
6	McGovern et al., 2015; RCT	Substance misuse treatment, USA n= 73/75/73	8-12 x individual sessions ICBT, weekly + TAU	1. Individual Addiction Counselling + TAU 2. TAU	59	NR (average 6.23 traumas)	NR	100	100	N	Y	6-months from baseline	M	[n=2: Saunders et al., 2016; Meir et al., 2015]
7	McGovern et al., 2011; RCT	Community substance misuse treatment, USA n=32/21	12-14 individual sessions, weekly + TAU	Individual Addiction Counselling + TAU	67	CSA 68% CPA 19% ASA 9% APA 2%	NR	100	100	Y	N	6-months from baseline	M	
	<b>Trauma Adaptive Recovery Group Education and Therapy (TARGET)</b>													
8	Frisman et al., 2008; RCT	Outpatient substance misuse treatment, USA n=141/71	8-9 x gender specific group-work sessions weekly +Trauma informed TAU	Trauma informed TAU	63	NR	NR	95 <sup>10</sup>	NR	N	Y <sup>11</sup>	12-months from baseline	S	[n=1: Ford & Russo, 2006]

10 PTSD: 61% PTSD, 34% PTSD+ DESNOS, 3% DESNOS only.

11 Treatment effect seen for self-efficacy measure. Not clear if valid and reliable assessment tools were used for other measures of substance misuse and not clear if differences are statistically significant.

	Study design	Setting, Country, Sample size (T/C)	Dosage	Control	F%	IPA	Recent IPA %	PTSD %	SUD (AUD) %	PTS Out-come T>C	SU Out-come T>C	Follow up length	QA	Supplementary studies
	<b>Seeking Safety (full and partial doses)</b> [n=2: Najavits, 2004; 2000]													
9	Hien et al., 2004; non-randomised quasi-experimental	Unclear, USA n=41/34/32	24 sessions: 12 x twice weekly individual sessions of SS	1. Relapse Prevention 2. Standard community care	100	NR	NR	88*	100	1.N 2. Y	1. N 2.Y	9-months from baseline	S	
10	Zlotnick et al., 2009; RCT	Women's prison, USA n=27/22	25 sessions: 3 x weekly for 6-8 weeks + post release, 1 hour 'booster' sessions for 12 weeks +TAU	TAU	100	94% sexual abuse, 90% physical abuse	NR	83*	27-94 (88) <sup>12</sup>	N	N	6-months from baseline	M	
11	Ghee, Bolling & Johnson, 2009; RCT	Residential SMT, USA N= 52/52	6 session of SS twice weekly + TAU	TAU	100	NR	NR	NR	NR	N	N	30 days	M	[n=1: Ghee et al., 2009a]
12	Desai et al., 2008; quasi-experimental nonequivalent control group design	Residential substance misuse services, USA n=91/359	Group or individual; 25 weekly sessions + TAU	TAU	100	Rape 68%, Prostitution 35%	NR	NR <sup>13</sup>	100 <sup>14</sup>	Y	N	6-months from baseline <sup>15</sup>	M	
13	Gatz et al., 2007; quasi-experimental nonequivalent control group design 'WCDV study'	Outpatient /residential substance misuse and mental health services, USA n=136/177	Twice weekly group-work for 31 sessions + intensive trauma informed care ***	Women only residential TAU	100	Any CSA or CPA 71%; moderate to high levels of CSA/CPA 39%.	52**	NR <sup>16</sup>	100 <sup>16</sup>	Y	N	12-months from baseline	M	

12 One month prior to prison entry.

13 PTSD diagnosis was not an inclusion criteria.

14 But unclear how this was measured.

15 12 month follow up not used here because of high attrition

16 Recent or within past five years.

	Study design	Setting, Country, Sample size (T/C)	Dosage	Control	F%	IPA	Recent IPA %	PTSD %	SUD (AUD) %	PTS Out-come T> C	SU Out-come T>C	Follow up length	QA	Supplementary studies
14	Hien, Wells & Brigham, 2009; RCT 'Women and Trauma study'	Community based substance misuse treatment, USA n=176/177	12-sessions - twice weekly group-work sessions for 6 weeks	Women's Health Education	100	CSA 70%, CPA 59% APA 85% ASA 68%	10 <sup>17</sup>	80*	100	N	N	12-months from baseline	S	[n= 12: Anderson & Najavits, 2014; Cohen et al., 2013; Hien et al., 2015; Hien, Campbell et al., 2010; Hien, Jiang et al., 2010; Morgan-Lopez et al., 2013, 2014; Ruglass et al., 2014; Ruglass et al., 2012; Killeen et al., 2008; Pinto et al., 2011; Resko & Mendoza, 2012]
<b>Seeking Safety + modules from Kubany's Trauma Therapy for Battered Women (2004) trauma related guilt, assertiveness training, managing contact with former abusers</b>														
15	Norman, n.d. <sup>18</sup> RCT	Outpatient psychiatric services, USA n=19/9	25 sessions (individual and group) <sup>19</sup> : twice weekly for 12 weeks.	12-Step facilitated therapy	100	CSA 72%, CPA 60%, ASA 57%, APA 56%	100 <sup>20</sup>	100	(100)	N	N	3-months from baseline	W	[n=1: Myers et al., 2015]
<b>Trauma Recovery and Empowerment Model (TREM)</b>														
16	Fallot et al., 2011; quasi-experimental nonequivalent control group design 'WCDV study'	Outpatient mental health service, USA n=153/98	33-sessions: 1 x weekly group-work for 33 weeks + intensive trauma informed care ***	TAU	100	CSA 72%, CPA 60% ASA 57% APA 56%	44**	NR <sup>^</sup>	10-34% <sup>21</sup>	N	Y	12 months from baseline	M	[n=3: Fallot & Harris, 2002; 2004; Harris et al., 2005]

17 % of sample reporting physical or sexual abuse in previous 30 days.

18 Data from Norman was unavailable, so information and QA assessment undertaken based on Cochrane assessment (Roberts et al. 2016).

19 Some received individually (15 SS and 6 12-Step) and some group format (16 SS & 3 12-step).

20 Inclusion criteria was one month out of an abusive relationship.

21 Depending on substance: 51% reported abstinence from alcohol, 47% abstinence from drugs, 30% abstinence from both alcohol and drugs.

	Study design	Setting, Country, Sample size (T/C)	Dosage	Control	F%	IPA	Recent IPA %	PTSD %	SUD (AUD) %	PTS Out-come T>C	SU Out-come T>C	Follow up length	QA	Supplementary studies
17	Toussaint et al., 2007; quasi-experimental nonequivalent control group design 'WCDV study'	Women only residential service, USA n=64/106	24 sessions: twice weekly group-work <sup>22</sup> for 8 weeks, then weekly for 8 weeks + intensive Trauma informed care ***	TAU	100	NR	50**	NR <sup>^</sup>	100	N	Y <sup>23</sup>	12-months from baseline	M	
18	Amaro, Dai et al., 2007; quasi-experimental nonequivalent control group design 'WCDV study'	Outpatient and residential substance misuse services, USA n=181/161	25 sessions: 1 x group-work sessions, weekly for 25 weeks + intensive trauma informed care <sup>24</sup>	TAU	100	100% reported history of any IPV	44**	NR <sup>^</sup>	100	Y	N <sup>25</sup>	12-months from baseline	M	[n=2: Amaro, McGraw et al., 2005; Amaro, Chernoff et al., 2007]
<b>Gender Responsive Treatment (Helping Women Recover + Beyond Trauma)</b> [n=2: Covington, 2000; Covington & Bloom, 2007]														
19	Messina et al., 2012; RCT	Women mandated to outpatient drug treatment, USA n=85/65	28-sessions of group-work (frequency unknown but within 15-24 months)	TAU	100	CSA 55% CPA 37% APA 66% ASA 53%	66	31	NR	N	N	18-20 months from baseline	M	
20	Swopes et al., 2015; quasi experimental matched comparison design	Women's prison USA n=59/82	48-sessions: three group-work sessions weekly for 16 weeks) (inc. additional modules on domestic violence, relapse prevention and 12-step	TAU	100	CSA 48%;	NR	48	NR	N	N	4-months from baseline	M	[n=1: Calhoun et al., 2010]

22 Women could complete a workbook session with a counsellor and also repeat that session in the group format, so viable for women to complete all 24 TREM sessions in group and all 24 workbook sessions.

23 Treatment found to be superior for measure of dissociation.

24 Intervention participants also received: (1) 3-sessions of women's leadership training [15 hours]; (2) 8-sessions of economic success in recovery [16 hours]; (3) 10-sessions of Pathways to Family Reunification and Recovery [15 hours]; (4) 12-sessions of Nurturing Program for Families [24 hours], plus an unspecified amount of individual case management.

25 Treatment not superior on ASI measure of substance use but post hoc analysis revealed superiority for abstinence rates.

	Study design	Setting, Country, Sample size (T/C)	Dosage	Control	F%	IPA	Recent IPA %	PTSD %	SUD (AUD) %	PTS Out-come T> C	SU Out-come T>C	Follow up length	QA	Supplementary studies
	<b>Relapse Prevention and Relationship Safety – Women's Wellness Programme</b>													
21	Gilbert et al. 2006) RCT	Methadone maintenance treatment, USA n=16/18	11 x group sessions & 1 individual session; twice weekly for 6 wks	1 hr info session on intimate partner violence	100	100% IPV	100	100 <sup>26</sup>	100	N	N	3-months from baseline	S	[n=1: Gilbert et al., 2005]
	<b>Dual Assessment and Recovery Track (DART)</b>													
22	Sacks et al. 2008; RCT	Outpatient substance misuse service, USA n=126/114	12 x group-work & individual sessions of trauma informed addiction counselling + psycho-education, advocacy skills	TAU	57	IPV 98% CSA/CPA 58%	NR	NR <sup>27</sup>	100	N	N	12-months from baseline	S	
	<b>Mindful Awareness in Body Orientated Therapy (MABT)</b>													
23	Price et al. 2012; RCT	Women only substance misuse service, USA n=31/15	8 x individual weekly sessions + TAU	TAU	100	CSA or CPA 63% ASA 48%	0 <sup>28</sup>	65	100	N <sup>29</sup>	N	9-months from baseline	M	[n=2: Price et al., 2012a; Price & Smith-DiJulio, 2016]

<sup>26</sup> PTSD was not an inclusion criterion for the study, 100% met criteria for at least 2/3 symptom clusters on the PCL-C.

<sup>27</sup> The mean GAIN Traumatic Stress Index was in the highest severity category, indicating a clinical level of stress related to trauma.

<sup>28</sup> Current intimate partner violence was a study inclusion.

<sup>29</sup> Although there were significant effects for the measure of dissociation.

	Study design	Setting, Country, Sample size (T/C)	Dosage	Control	F%	IPA	Recent IPA %	PTSD %	SUD (AUD) %	PTS Out-come T> C	SU Out-come T>C	Follow up length	QA	Supplementary studies
<b>Women and Co-occurring Disorders and Violence (WCDV) Study</b>														
24	Morrissey, Jackson et al. 2005; quasi-experimental nonequivalent control group	Mental health, substance use, IPV services, USA n=1415/1314	9 study sites delivered: Seeking Safety (n=4), TREM (n=3) or ATRIUM^^ (n=1); Triad Women's Group^^ (n=1), varying lengths ***	TAU	100	CSA 62% CPA 61% APA 85% ASA 60%	47-55	NR^	NR^	Y <sup>30</sup>	N	12-months from baseline	M <sup>31</sup>	{n= 13: Brown et al., 2007; Heckman et al., 2004; Cadiz et al., 2004; Morrissey, Ellis et al., 2005; Cocozza et al., 2005; Domino et al., 2007; VandeMark et al., 2004; Savage & Russell, 2005; Moses & D'Ambrosio, 2004; Moses, Reed et al., 2003; Gilbert et al., 2011, Markoff et al., 2005; Mockus et al., 2005}

30 Significant heterogeneity found across sites. Greater PTSD effect sizes (but not drug/alcohol) seen in intervention with high contrast in integrated counseling to the control, but not drug/alcohol measures.

31 Data also drawn from Morrissey, Ellis et al., 2005; Cocozza et al., 2005; McHugo, Kammerer et al., 2005.

The majority of studies compared a psychological intervention to address both PTSD and substance use with a control condition of usual care consisting of standard substance use treatment. The exceptions were the control sites for WCDV study which varied and included substance use or mental health treatment, and the Women and Trauma study (Hien, Wells, & Brigham, 2009) which used Women's Health Education (WHE) comprising group-work sessions such as bodily self-care and HIV prevention.

The methodological rigour of the trials varied. Seven were classed as strong, 12 as moderate and 5 as weak (See Table 2). Typically, weaker studies did not report on the controlling of confounding variables, had high study attrition and/or treatment blinding processes were unclear. All but three trials (Desai, Harpaz-Rotem, Najavits, & Rosenheck, 2008; Gilbert et al., 2006; Perez-Dandieu & Tapia, 2014) had supplementary papers, or information in the primary paper, which contributed towards the research questions.

### **3.3.2.2 Supplementary studies**

Of the 47 supplementary papers, 17 were classified as practitioner/ organisational /service user knowledge and provided detail of content, theories of change, and/or lessons learnt to guide future implementation. Limitations included a lack of methodological transparency where process evaluation or other qualitative feedback was used to draw conclusions. The remaining 30 were either secondary data analyses (n=24), qualitative (n=3), or mixed methods studies (n=2). A large proportion related to either the WCDV trial (n= 13) or the Women and Trauma study (n=12). Secondary data analyses by their nature are subject to methodological constraints that limit the strength of conclusions drawn. As Hien et al. (2015) point out, one needs to be careful in drawing causal influences in moderator analysis where the moderator of interest was not randomized, and mediator analyses should advance the generation of hypotheses rather than draw firm causal inferences. However, the majority of analyses in the Women and Trauma study were planned a priori and involve relatively large sample sizes (Hien et al., 2015). Several analyses associated with the WCDV trial attempted to address some of the methodological constraints of non-randomised controlled designs (Cocozza et al., 2005; Morrissey, Ellis, et al., 2005). The three qualitative studies used focus groups or interviews and had limitations related to sample selection

and data analysis transparency. The majority of supplementary studies related to present-focused models only.

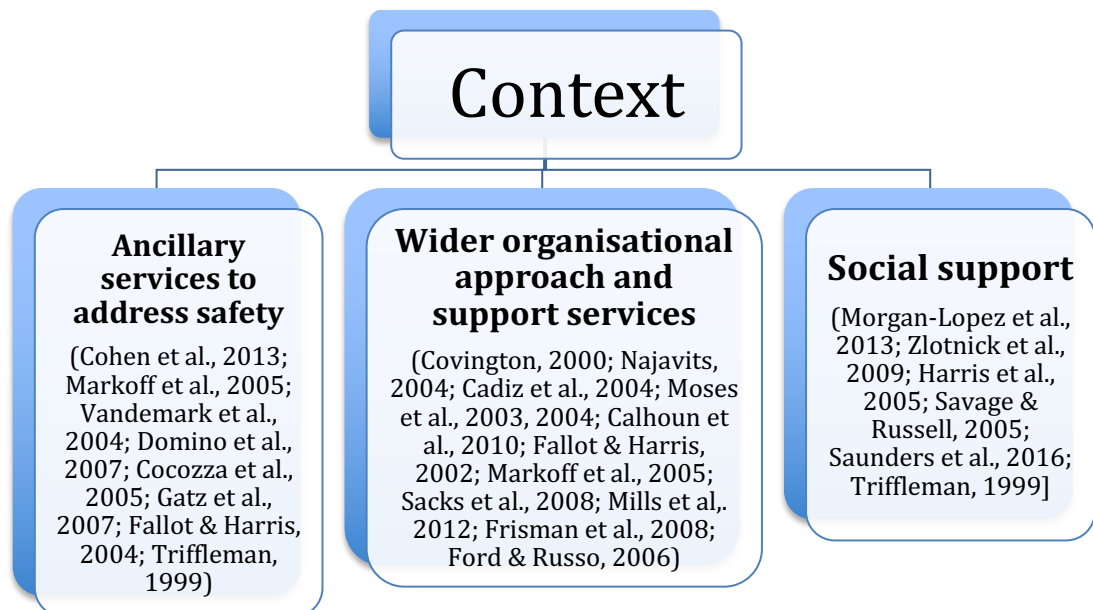
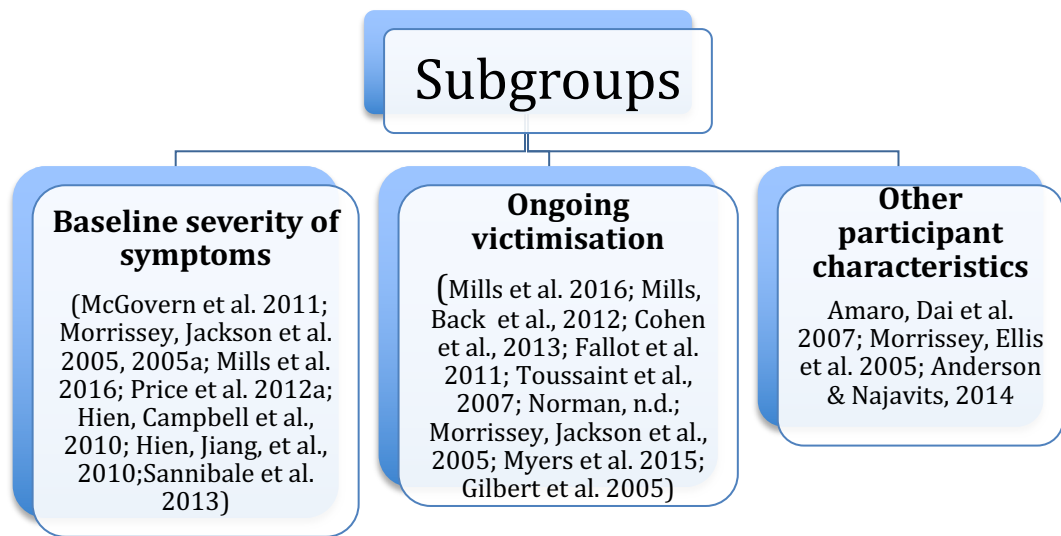
### **3.3.2.3 Participant characteristics**

Samples involved between 53%-100% of female participants. Participants across all trials reported high levels of lifetime IPA, although the descriptions varied and focused mostly on physical and sexual abuse. One trial included recent domestic violence survivors only (Norman, n.d.) but few studies reported on recent IPA at baseline. Studies varied in terms of the measures used for assessing PTSD (self-report vs. clinician interview) and participant numbers meeting DSM PTSD criteria (range 31-100%) or SUD (range 10-100%) at baseline (See Table 2). The studies pertaining to the WCDV multi-site study (Amaro, Dai et al., 2007; Fallot et al., 2011; Gatz et al., 2007; Morrissey, Jackson, et al., 2005; Toussaint et al., 2007) required a current diagnosis of SUD or a mental health disorder with a history of other in past 5 years

## **3.4. Findings**

Over-arching themes are presented according to the a priori categories of: 1) *subgroups* (severity of baseline symptoms, ongoing interpersonal abuse); 2) *contextual factors* impacting on treatment outcomes (ancillary services to address safety, wider organisational approaches, ongoing social support); 3) *mechanisms of action* (alternative coping skills, relational approaches, PTSD as a mediator); and 4) *implementation considerations* (staff skills, treatment retention, programme fidelity, delivery format and adverse events). Figure 6 provides a visual mapping.





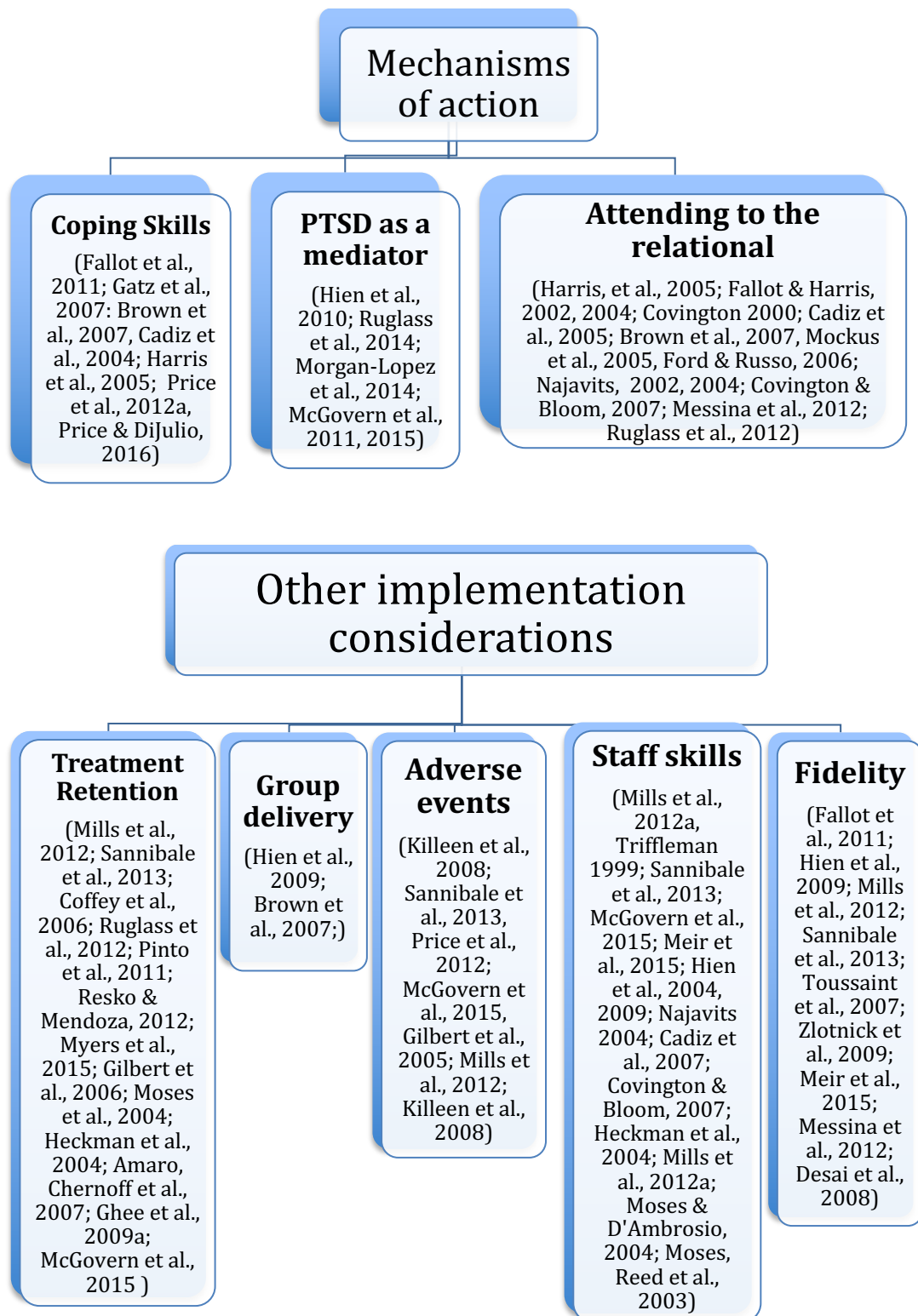


Figure 6: Thematic mapping of the key themes in the systematic review narrative analysis

### 3.4.1 Subgroups

#### 3.4.1.1 Women with more severe baseline symptoms relating to PTSD and substance use

Four trials noted that severity of baseline PTSD scores was positively associated with greater PTSD reductions among participants in the treatment condition (Hien, Campbell, Ruglass, Hu, & Killeen, 2010; McGovern, Lambert-Harris, Alterman, Xie, & Meier, 2011; Morrissey, Jackson, et al., 2005). For example, McGovern et al., (2011) noted a large treatment effect in PTSD reduction, among the more severe subgroup (n=37) relative to the entire sample. However, it is unclear how many of these were women. This group also reported preferring integrated treatment over regular addiction counselling. For the subgroup of women who had severe baseline PTSD scores (n=81 treatment, n=82 control), a trend emerged in the WCDV intervention sites providing more integrated interventions. A greater number experienced substantial improvement in PTSD at the 12-month follow-up compared to the control (30% vs. with 21%) (Morrissey et al., 2005). Both these studies showed mixed treatment effectiveness relating to PTSD reduction in the overall samples. A significant treatment effect for PTSD was found amongst the subset of women randomised to the intervention group in the Women and Trauma study, who were actively using alcohol at baseline<sup>32</sup> (note that 51% of the sample reported abstinence at study entry) (Hien, Campbell, et al., 2010). The Women and Trauma study, involving 353 women with a diagnosis of PTSD and SUD was rated as strong according to the Quality Assurance (QA). The trial found that based on 'average effects' there was no overall treatment effect for PTSD or substance use, measured by clinical interview, when comparing Seeking Safety, a present-focused integrated intervention, with an active control (Hien et al., 2009). The one trial of Mindful Awareness in Body-Oriented Therapy (MABT) involving women only did not evidence an overall treatment effect for PTSD nor substance use, however it was superior for reducing dissociation, suggesting its effectiveness for women with certain symptoms found in Complex PTSD (Price et al., 2012).

With regards to substance use reduction, the 6-month follow-up outcomes in the WCDV study illustrated that women with high baseline scores on alcohol use severity (ASI-A) experienced a

---

<sup>32</sup> N = 353; Alcohol misuse was defined as either (1) daily alcohol use in the prior 30 days or (2) at least 1 day of alcohol use to intoxication in the prior 30 days (Hien, Campbell et al., 2010).

greater treatment effect for drug use severity than others. This was not found for the baseline drug use severity subgroup nor is it clear if this was sustained at the 12-month follow-up (Morrissey, Jackson, et al., 2005). Among the severe PTSD subgroup, the study by McGovern et al. (2011) illustrated a treatment effect in reported days of drug use, but not alcohol use days (for which the control, individual addiction counselling, was found to be superior). One trial involving a past-focused treatment model using exposure therapy found that participants who dropped out of treatment before reaching the exposure sessions also had higher baseline PTSD scores and days drinking, and were then less likely to experience clinically significant change in PTSD (Sannibale et al., 2013). However, secondary data analysis of another trial involving exposure found baseline substance use severity was not associated with PTSD symptom change (Mills et al., 2016). For both these exposure-based trials, it is unclear what percentage of these sub-groups comprised women.

#### **3.4.1.2 Women experiencing recent IPA**

The WCDV study meta-analysis showed a treatment effect on PTSD at 12 months but not substance use. However, women who sought hospital treatment for any current IPA in the 3-months prior to the study experienced significantly less PTSD reductions (effect size =  $-.705$ ,  $p < .01$ ) from the intervention at follow-up (Morrissey, Jackson, et al., 2005). However, no firm conclusions can be drawn about the relationship between recent physical abuse and the ability of interventions to reduce PTSD symptoms because this association was not seen at the 6-month follow-up and the analyses used to identify this effect tested a large number ( $n=45$ ) of other covariates at the same time. Another WCDV study analysis showed that women reporting risk of re-victimization at baseline (within past 6 months) had significantly lower odds of responding well to integrated treatment on PTSD symptoms<sup>33</sup> at 12 months compared to those who did not ( $OR=0.59$ ,  $p=0.03$ ). However, both these analyses do not indicate the role of re-victimization at follow-up and the association with treatment outcomes. In two WCDV study sites, using the Trauma Recovery and Empowerment model (TREM), and reporting on participant IPA at follow-

---

33 defined as scoring  $< 20$  on the Posttraumatic Diagnostic Scale (Foa et al., 1997)

up, the treatment group did not experience greater reductions in overall experiences of current violence. However, both treatment groups reported significant increases in feelings of safety (Fallot et al., 2011; Toussaint et al., 2007), which may indicate a reduction in certain types of abuse.

In the Women and Trauma study, women receiving Seeking Safety reporting abstinence from substances at baseline were at significantly reduced odds of experiencing IPA at follow-up compared to women who were actively using or those who were abstinent in the control group (Cohen, Field, Campbell, & Hien, 2013). The authors suggest that women who were abstinent were better able to implement the safety strategies for IPA learned in Seeking Safety. A different trial of Seeking Safety was tailored for recent intimate partner violence survivors with AUD, incorporating additional modules from Kubany's Cognitive Trauma Therapy for Battered Women (See Appendix 3). This study involved small sample sizes and methodological constraints and the intervention did not show any superiority on either PTSD or alcohol use at post-treatment compared to 12-step facilitated therapy (Norman, n.d). The aim of the study by Gilbert et al. (2006), involving women in methadone maintenance treatment, was to reduce intimate partner violence alongside substance use. The intervention had explicit focus on safety planning within each session but PTSD psycho-education was limited to one session only (Gilbert, El-Bassel, & Manual, 2005). The intervention had an effect on reducing the risk of minor abuse (OR 7.05 (95% CI 1.00-49.81) and a trend towards reduced substance use but not PTSD (Gilbert et al., 2006). This would seem to suggest interventions require elements aimed at both reducing IPA and providing skills to address the trauma sequelae resulting from abuse.

What remained unanswered in these studies was the role of ongoing IPA, interacting with or mediating the causal pathway between the intervention and participants' PTSD and substance use reduction. The trial of Concurrent Treatment of PTSD and SUD Using Prolonged Exposure (COPE) (Mills et al., 2016) did explore this correlation. Sixty percent of participants (n=33, number of women unknown) experienced a further physical or sexual IPA over the 9-month follow-up (25.6% physical attack, 17.9% being threatened or held captive, 12.8% sexual assault), however,

after controlling for baseline PTSD severity, exposure to these forms of IPA was not significantly associated with change in PTSD symptom severity at follow-up (substance use was not explored).

#### **3.4.1.3 Other participant characteristics**

The WCDV and Women and Trauma studies also explored the participant socio-demographics of disability and ethnicity in relation to outcomes. One WCDV site found that ethnicity did not moderate the effects of the intervention on any of the main outcomes, suggesting the integrated intervention was equally efficacious for women across all ethnic groups (Amaro, Dai et al., 2007). Contradictory results were found when considering women with physical health disadvantages. In the WCDV study, women with a serious physical illness or disability had poorer PTSD outcomes regardless of participation in treatment or comparison groups (Morrissey, Ellis, et al., 2005). However, in the Women and Trauma study, women receiving a pension for disabilities (n= 20) who received Seeking Safety had superior reductions in PTSD up to the 12-month follow-up (Anderson & Najavits, 2014).

#### **3.4.2 Contextual factors**

##### **3.4.2.1 Ancillary services to address ongoing safety risks**

It is unclear in the Women and Trauma Study what practical and external support was provided for women experiencing ongoing trauma due to IPA, such as intimate partner violence, although it is likely to have been minimal (D. Hien, personal communication, 10 May 2016), and the researchers concluded that there is a need to better address intimate partner violence concurrently with PTSD and substance use (Cohen et al., 2013). The WCDV study stressed the importance of safe working principles, such as not allowing an abusive partner to enroll in the same agency (Markoff et al., 2005), and coordinating treatment services with crisis support services, with some sites offering counseling for intimate partner violence (VanDeMark, Brown, Bornemann, & Williams, 2004). However, analysis of external service use by participants in this trial at the 6-month follow-up (Domino, Morrissey, Chung, & Nadlicki, 2007) suggests that the multiple components comprising the intervention did not reduce women's need for medical treatment, and/or encourage access to shelters when facing re-victimization. However, some

control sites over the course of the study started to run groups for intimate partner violence potentially masking any treatment effect on these variables (Cocozza et al., 2005, Gatz et al., 2007). Further process evaluation emphasised the importance of providing access to safe housing to avoid returning to abusive partners or family members, despite women having learned skills to keep themselves safe. As women were provided with safe accommodation, they described feeling freer to use many of the skills taught in the integrated intervention TREM (Fallot & Harris, 2004).

#### **3.4.2.2 Wider organizational approach and support services**

Implementation guidance relating to several of the present-focused models described in some of the studies stressed the importance of trauma informed practice (TIP) for healing (Cadiz et al., 2004; Calhoun et al., 2010; Covington, 2000; Moses & Ambrosio, 2004; Najavits, 2004). Such an approach means instigating practice at an organisational level as well as an individual/clinician level, centred around five core principles: trauma awareness, safety, trustworthiness, choice and collaboration, and building of strength and skills. Focus groups with participants and staff involved in the trial of Gender Responsive Treatment (GRT) in a prison setting highlighted how the lack of TIP by wider prison staff often undermined the progress made within group sessions (Calhoun et al., 2010). While this research suffered from methodological limitations regarding sample selection and data analysis transparency, this finding does chime with the rationale and theory behind TIP. The WCDV study was unique among all the studies in this review, in that the integrated interventions were delivered within a service delivering TIP which included service staff trained in TIP and the provision of multiple ancillary group-work programmes and support services such as advocacy and groups for intimate partner violence (see Appendix 4). This makes it difficult to conclude what role, if any, the integrated interventions contributed to the study treatment outcomes. However, an analysis of programme level variables was undertaken to explain site specific outcomes heterogeneity. Only the integrated group-work interventions (not the type or number of additional services received or mode of delivery) could explain the more favourable outcomes seen in mental health (including PTSD) and substance use across some sites (Cocozza et al., 2005). In contrast, other trial authors recommended an increased focus on case management and support services for retention (Mills, Teeson et al., 2012) and after-care

(Zlotnick, Johnson, & Najavits, 2009). The Women and Trauma study also identified that women at less risk of substance use/infrequent use at the 12-month follow-up reported more contact with substance use treatment services following the integrated intervention, highlighting the importance of sustained and long-term treatment and after-care (López-Castro, Hu, Papini, Ruglass & Hien, 2015).

#### **3.4.2.3 The role of ongoing social support**

The Women and Trauma study showed that women in the Seeking Safety intervention who engaged in additional 12-step affiliated peer support post-intervention showed significantly reduced alcohol use at follow-up compared to women in the control group (Morgan-Lopez et al., 2013). Whilst attendance at 12-step programmes was not randomised, limiting casual inference, other studies identified a similar theme. In the prison-based study, also involving Seeking Safety, attendance at follow-up intervention sessions with other women post-release also seemed to be associated with better drug use reduction (Zlotnick et al., 2009). In the WCDV study, women in the intervention sites who practiced their recovery alone often relapsed (Harris, Fallot, & Berley, 2005). However, the type and quality of social support and networks were important. In the WCDV study, family members were found to be less supportive in terms of providing emotional support and promoting recovery from PTSD compared to friends (Savage & Russell, 2005), with women's families sometimes encouraging drug use and viewing their attempts at sobriety with derision and delusion (Harris et al., 2005). In one site, the more relatives in a woman's network, the less support and healing from trauma she experienced. Integrated CBT for PTSD trial analysis (59% women) also showed that increases in family and social problem severity from baseline to 6-month follow-up were significantly associated with increases in PTSD and alcohol, but not drug use (Saunders et al., 2016).

#### **3.4.3 Mechanisms of action in the interventions**

##### **3.4.3.1 Development of alternative coping skills for different symptom clusters**

The trial of Integrated CBT for PTSD was particularly useful for reducing re-experiencing of trauma (McGovern et al., 2011) in the sample as a whole; and in the Women and Trauma study,



Seeking Safety was beneficial for hyper-arousal symptoms amongst those reporting alcohol use at baseline (Hien, Campbell, et al., 2010). The mindfulness intervention (MABT) was superior for dissociation (Price et al. 2012). This suggests the integrated treatments were superior over standard substance use treatment for addressing certain PTSD symptom clusters. One of the WCDV study analyses suggested it was the improvement in coping skills gained over the 12-month follow-up that mediated in part improvements in PTSD and drug use (Gatz et al., 2007), regardless of treatment condition. Although formal mediation analyses were not undertaken, a positive relationship was also found between developing trauma coping skills through TREM and treatment outcomes relating to substance use, PTSD, and feelings of safety (Fallot et al., 2011). Women who reported success in sustained abstinence had developed coping skills and strategies (e.g. mindfulness) for managing emotions and triggers (Harris, et al., 2005). Eighty-four percent of women receiving MABT found the intervention positively influenced a reduction in their substance use, consistently explained through the facilitation of emotional regulation (Price, Wells, Donovan, & Brooks, 2012a).

#### **3.4.3.2 Attending to the relational**

Process evaluations from several trials highlighted the importance of attending to the relational connection participants had with their self and others. Women receiving TREM in the WCDV sites identified self-awareness, connection with other women, and regaining a sense of purpose, meaning and spirituality, as strong recovery facilitators ( Fallot & Harris, 2004; Harris et al., 2005). The WCDV study researchers describe the profound emptiness and bleakness women felt from years of addiction and IPA, coining the term '*repersonalisation of the self*' to describe the series of activities and commitments needed to fill such a void (Harris et al., 2005).

All the WCDV sites provided long term integrated group interventions (4-9 months) combined with many other services suggesting the need for holistic and long-term support to address issues of self-identity. Clinicians delivering Seeking Safety for the WCDV study believed that the session on self-compassion had the most impact on participants (Cadiz et al., 2004); this was corroborated by women themselves who stated that feeling safe and bonding with other women with similar experiences was one of the most important components (Brown et al., 2007), although

it is unclear the sample size this feedback is based on. Eleven female peer researchers in the WCDV study described how their involvement altered their self-perceptions through having their voices heard and respected (Mockus et al., 2005).

The researchers involved in delivering the past-focused intervention COPE highlight how for survivors of IPA, as opposed to other forms of trauma, the therapeutic alliance formed between therapists and participants may be of particular relevance for treatment engagement (Mills et al., 2016). Only one study explored the role of alliance on treatment outcomes. In the Women and Trauma Study, participants in Seeking Safety reported a greater therapeutic alliance at the beginning of the intervention (week 2) compared to women in the control group. However, across both arms, women who reported greater alliance early on in treatment also had greater retention in groups. This group of women then showed more marked decreases in PTSD severity post treatment, but not substance use (Ruglass et al., 2012). It is noteworthy that alliance across both groups was high despite practitioner initial concerns that a structured manualised approach may limit their ability to develop an authentic relationship with the participants.

### **3.4.4 Other mechanisms of action**

#### **3.4.4.1 PTSD as a mediator in the relationship between intervention and substance use reduction**

A laboratory study found support for the hypothesis that negative emotion related to trauma is a mechanism of alcohol craving among a mixed sample of men and women (Coffey, Stasiewicz, Hughes, & Brimo, 2006). Similarly, the Women and Trauma study demonstrated that PTSD reductions were most likely to be associated with substance use reduction, with minimal evidence of a reverse relationship (Hien, Jiang, et al., 2010). Furthermore, changes to PTSD (severity and frequency) were found to mediate the relation between Seeking Safety and reductions in alcohol and cocaine use for participants who had a high likelihood of attending most of the sessions (Morgan-Lopez et al., 2014). However, the exploratory nature of these mediation analyses means no clear conclusions can be made about temporal relations of substance use reduction following PTSD. Furthermore, for those attending a 'moderate' dose of treatment, substance use change

was not mediated by PTSD reductions. Another analysis showed a treatment effect for substance use reduction, among those who were heavy substance users at baseline, particularly stimulant users, and whose PTSD had reduced significantly over time (Hien, Jiang, et al., 2010; Ruglass, Hien, Hu, & Campbell, 2014). The authors postulate that Seeking Safety was more effective for these groups because those with more severe substance use also had more severe PTSD.

The first trial of Integrated CBT for PTSD (59% women) also points towards PTSD reduction as a potential mediator of substance use reduction (McGovern et al., 2011) however, this was not replicated in the larger follow-up trial in (67% women) (McGovern et al., 2015), and also not seen in the one mindfulness-based study (MABT) (Price et al., 2012). This suggests that PTSD is not a mediator in the relationship between intervention and substance use reduction. However, in these three studies, some of the sites offered Seeking Safety groups as part of standard care; given this is an active treatment for both PTSD and substance use, and we do not know who received this treatment and to what dosage, it is not clear how this impacted on overall participant outcomes or mediation pathways.

### **3.4.5 Implementation considerations**

#### **3.4.5.1 Treatment retention**

Treatment 'engagement' was measured differently across studies and, where reported, the range was 45%-100%. In two trials involving prolonged exposure, approximately 45% of participants stopped treatment before the active exposure began (Mills, Teeson et al., 2012; Sannibale et al., 2013). In these studies, characteristics of those who dropped out are not reported. However, in the laboratory-based exposure study (Coffey et al., 2006), the study completers (n=17) did not differ from non-completers in terms of gender, PTSD baseline scores, alcohol use, or early childhood abuse.

In the Women and Trauma study, baseline PTSD severity or substance use were not related to attendance. Factors associated with increased rates of attendance (>50% of sessions) in the treatment were participant characteristics related to being older, having greater education,

attendance at 12-step programmes, and stronger therapeutic alliance with the group facilitators (Ruglass et al., 2012). It is notable that the site with the highest retention also provided childcare (Pinto, Campbell, Hien, Yu, & Gorroochurn, 2011). However, analysis of early attrition in this same study found that logistical barriers, such as lack of transportation and presence of children in the home, were not associated with the reasons for non-engagement (Resko & Mendoza, 2012). Study factors not captured related to resource access (e.g., availability of family childcare support or good public transport) may have been influential (Resko & Mendoza, 2012).

One study, involving survivors of intimate partner violence (Norman, n.d.), experienced particularly high drop-out with only 45% of treatment participants (receiving 25 sessions over 12 weeks) engaging in 6+ sessions (Myers, Browne, & Norman, 2015). The secondary data analysis of treatment engagers identified that older participants who had significantly fewer dependents were more likely to engage in treatment. On the other hand, the other trial involving survivors of intimate partner violence, in methadone maintenance clinics (Gilbert et al., 2006) experienced particular high treatment participation. All 34 women attended at least nine of the 12-sessions. This may well be due to the fact that participants received financial incentives for each session attended. In the WCDV study, in order to promote retention in services for women facing many competing demands, assistance with childcare and transportation and the placement of groups in convenient community locations were needed. Providing assistance with basic needs (housing, food, income etc.) and peer support services were other effective responses (Moses & Ambrosio, 2004).

Two WCDV sites, delivering either the Seeking Safety or TREM intervention over 25 weekly sessions, recommended that shorter term group-work may be advisable for engaging women into treatment who are in early stages of substance use recovery (attrition was 55% in the treatment groups) (Amaro, Chernoff, Brown, Arévalo, & Gatz, 2007). The Women and Trauma study involved a condensed version of Seeking Safety (12-sessions over 6 weeks). Of those women attending at least one session, 74% completed >50% of sessions (Hien et al., 2009). A different study involving a condensed version of Seeking Safety delivered in residential treatment during a 30 day period, also experienced higher retention, which may have been due to the shorter

treatment length (70.6% treatment retention vs 38.5% in the control,  $p < 0.001$ ) (Ghee, Johnson, Burlew, & Boiling, 2009a).

#### **3.4.5.2 Group delivery format and modifications**

Hien et al. (2015) illustrate how retention was maximized in the 'Women and Trauma' study. This included offering open enrollment in groups, free sequencing of sessions, and termination from the study only instigated if participants missed four consecutive sessions without making contact with study staff. The four sites offering Seeking Safety group-work in the WCDV sites delivered varying numbers of sessions (range 12-31), in line with the flexibility afforded by the intervention (Najavits, 2004). Supplementary data from a number of the present-focused studies commented on the adaptations made to ensure programmes were delivered with cultural competency. Many of the nine WCDV study sites served women from diverse cultural backgrounds e.g., 66% of women identified as Black and Minority Ethnic (BME) in one site (Amaro, McGrawn et al., 2005). All the study sites involved service users' active co-collaboration in the design and delivery of services, increasing the chance that services met individual needs (Mockus et al., 2005). Examples of practice introduced as a direct result was the inclusion of culturally sensitive items in the trauma assessment (e.g., experiences of racial discrimination), translation of materials into Spanish, and discussions about spirituality in trauma recovery.

#### **3.4.5.3 Adverse Events**

Only five trials reported on adverse study events; of which the majority reported none, or equal reports of events across treatment and control groups (Gilbert et al., 2006; Killeen et al., 2008; McGovern et al., 2015; Price et al., 2012; Sannibale et al., 2013). The adverse events experienced by participants in the Women and Trauma study, were related to increased symptoms of PTSD, depression and other anxiety symptoms (Killeen et al., 2008). In one trial of prolonged exposure, more participants in the control group attempted suicide compared to the treatment [OR=0.32 (95% CI, 0.06-1.76)], however, all individuals reported this was not related to study participation and remained involved in the study (Mills, Teeson et al., 2012).

#### **3.4.5.4 Staff Skills**

All interventions varied in terms of the clinical qualifications required by the therapists/clinicians. For example, the past-focused interventions often placed emphasis on the need for post-graduate qualifications in counselling or psychology, whereas the formal clinical qualifications of the clinicians were more varied in the present-focused interventions. For example, in the ICBT for PTSD trial (McGovern et al., 2015), clinicians were not excluded based on education or level of certification (Meier et al., 2015). Only 54% of the clinicians involved in the Women and Trauma study held post-graduate qualifications (Hien et al., 2009).

Interestingly, Najavits (2004) describes how criteria for clinicians to deliver Seeking Safety originally involved a post-graduate mental health degree and skill specific training (e.g. CBT, substance use). However, over time it became apparent that the most important staff credentials related to more nuanced skills of passion and commitment to the work, along with openness to adopting manualised practice. However, if the clinician has limited background in the subject area, then specialist training and supervision is encouraged (Najavits, 2004). Similarly, all nine WCDV study sites concluded that integrated group-work programme and wider TIP requires higher levels of clinical skills than are usually found in community-based substance use treatment services (Moses et al., 2004).

Covington & Bloom (2007) recommend that staff should undertake self-reflection and examination of their own values and attitudes towards working with this client group. Echoing Najavits (2000), the staff qualities deemed as crucial include consistency in caring and availability, pursuit of ongoing training, collaborative and individualised approaches to treatment, and acting as a visible advocate for women. Several studies also highlighted the importance of staff self-care and regular supervision provided by senior clinicians with extensive TIP (Cadiz et al., 2004; Heckman et al., 2005; Mills, Back et al., 2012; Moses et al., 2003; Moses & D'Ambrosio, 2004).

#### **3.4.5.5 Adherence to treatment fidelity**

Just over half of the trials (n=14) discussed assessment of adherence to treatment fidelity, undertaken through direct session observation or reviewing videotaped sessions. Several studies used quantitative checklists and reported good mean fidelity scores (Fallot et al., 2011; Hien et

al., 2009; Meir et al., 2015; Mills, Teeson et al., 2012; Sannibale et al., 2013; Toussaint et al., 2007; Zlotnick et al., 2009). Several studies engaged external support for supervision to support the study clinicians maintain or improve competency throughout the study (Desai et al., 2008; Hien et al., 2009; Meier et al., 2015; Messina et al., 2012).

The secondary data analysis of ICBT for PTSD McGovern et al., 2011, 2015) set out to explore the impact of clinician adherence to the manual, and relation to participant outcomes. The analysis found mixed results: higher adherence to the fidelity of the treatment and competence by clinicians was associated with better PTSD reductions among participants at follow up but lower substance use reduction (Meier et al., 2015). The opposite was found amongst clinicians delivering the treatment as usual for substance use. The authors suggest this may be due to the content of the integrated intervention which is geared towards PTSD reduction.

### **3.5. Discussion**

#### **3.5.1 Pathways to PTSD symptom and substance use reduction**

Few trials demonstrated a treatment effect for substance use reduction, but some illustrated reduction for PTSD symptoms. This echoes the conclusions of previous literature reviews (Najavits & Hien, 2013; Roberts et al., 2016;), indicating that entrenched substance use may be harder to treat than PTSD in time-limited interventions. Many of the secondary data analyses presented also focus on PTSD reduction only and taken together, several suggest that women with more severe PTSD baseline scores experienced greater PTSD reductions from integrated treatment. There was some evidence that PTSD reduction leads to substance use reduction, supporting the self-medication theory and highlighting the importance of targeting PTSD symptoms in their own right as a mechanism of action. However, the results from other studies, albeit those with mixed samples of men and women, indicated there may be more than one pathway to substance use reduction. For example, the notion that substances are used to 'self-medicate' wider emotional regulation difficulties (Kramer et al., 2014) as well as PTSD certainly appears plausible for women experiencing ongoing IPA and multiple mental health problems.

### **3.5.2 The role of different coping skills**

All interventions contained programme content with varied coping strategies: cognitive (e.g. addressing negative self-talk), behavioural (e.g. safety planning), and body-based (e.g., breathing, bodily interoception and self-care), designed to promote new and healthier ways to cope with trauma symptoms and substance cravings or triggers. However, less was said about the *type* of coping skills women found most useful, nor their differential impact on the different symptom clusters or external stressors. For example, the facilitation of mind-body awareness was clearly valued by women and may be particularly useful for dissociation symptoms (Price et al., 2012a). It is interesting to note that the control group in the Women and Trauma study involved health education related to the body, and the authors postulate that this may have been an active ingredient in women's improved outcomes for PTSD or substance use in the control group (Hien et al., 2009).

The theoretical underpinnings of mindfulness treatments point to the enhancement of the attentional regulatory capacity for inducing the para-sympathetic response and regulating arousal (Kelly & Garland, 2016), and reducing reactivity to substance-related cues (Li et al., 2017). The targeting of negative trauma-related beliefs through cognitive strategies have been established as key mechanisms in the reduction of PTSD amongst a variety of trauma survivors (Ehlers et al., 2013), and can also be conceived as a key emotional regulation strategy (Aase et al., 2018). Avoidance coping (escape or withdrawal) has been found to exacerbate drug use, PTSD, and depression among women experiencing intimate partner violence (Flannigan, Jaquier, Overstreet, Swan, & Sullivan, 2014) so the promotion of other coping strategies would appear particularly relevant to this treatment group.

### **3.5.3 Attending to relations with self and others**

The qualitative studies in this review also highlighted the importance of rebuilding women's positive relationships with themselves and others, echoing established goals in the treatment for PTSD and models of working with survivors of IPA (Anderson, Renner, & Danis, 2012; Herman, 2001; Warshaw et al., 2013). Therefore, treatment that facilitates peer bonding among women with similar experiences, as well as treatment components found in many integrated interventions



such as self-compassion, self-identity, and self-care (Covington, 2000; Fallot & Harris, 2002), appear particularly crucial for women with histories of IPA, potentially influencing both trauma-reappraisal and emotional regulation. However, the work to re-establish identity lost to substance use and IPA is likely to require long term support from substance use services extending beyond group-work treatment.

Wider research in the treatment of mental health conditions, as well as therapeutic responses to victims of abuse, hypothesize that the wider contextual/relational aspects of therapy such as therapeutic alliance and therapist empathy account for positive outcomes more than techniques used (Greenberg, 2016; Najavits, 1994; Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998). For those with less severe symptomology, aspects common to groups and therapy (therapeutic alliance, meeting others, not feeling alone) may be sufficient to promote recovery (Zandberg et al., 2015), but those with more severe PTSD and/or substance use symptoms may require integrated interventions.

### **3.5.4 Targeting emotional regulation**

Increasing attention is being paid to trans-diagnostic treatment targets, that is to say key 'difficulties' that may transcend different 'disorders' and which may prove influential to target (Sloan et al., 2017). This may be particularly relevant for survivors of trauma for whom PTSD symptoms often exist alongside other co-occurring mental health problems (Breslau et al., 1997; Rees et al., 2011). Emotional regulation has been implicated in the causal pathway between PTSD and substance use (Tull, Bardeen, DiLillo, Messman-Moore, & Gratz, 2015), is one of the most important treatment targets for chronically traumatized people (Van der Kolk, 2014), and has been found to moderate the efficacy of prolonged exposure on PTSD and substance use outcomes (Hien, Lopez-Castro, Papini, Gorman, & Ruglass, 2017)<sup>34</sup>. Moreover, the targeting of

emotional regulation may also explain why some PTSD interventions have also resulted in decreased symptomology of other co-morbid mental health problems (Bisson et al., 2013).

### **3.5.5 Implications of contextual factors for treatment implementation**

The identification of active treatment ingredients cannot be considered in isolation from the wider contextual factors facing women such as ongoing victimisation and family problems, a point also supported in the wider literature (Galvani, 2007; Mills et al., 2018). However, lack of monitoring of new IPA experienced post-baseline in most of the studies under review precluded any conclusions about the correlation with treatment outcomes. A meta-analysis of 11 integrated present-focused interventions targeting women in substance use treatment with experiences of IPA (including all of the WCDV study sites), concluded that women reporting abuse in the six-months prior to baseline experienced better substance decrease compared to women with other forms of trauma (Fowler & Faulkner, 2011). However, the role of these interventions in reducing victimisation during the studies and the corresponding impact on treatment outcomes was unclear. Given the wider literature that implicates IPA in exacerbating PTSD symptoms, other psychological distress and substance use (Bailey, 2017; El-Bassel et al., 2005; Sullivan et al., 2016) future trials should measure ongoing victimization during the intervention and at follow-up, emotional, physical and sexual.

These safety concerns have implications for the wider service environment in which interventions are delivered. Several studies in this review maintained that integrated interventions should only be delivered within the context of wider organisational TIP, a principle also supported by PTSD treatment guidelines internationally (Australian Government, 2013; SAMHSA, 2014). Service practitioners should also undertake sustained external advocacy and multi-agency support for women experiencing ongoing victimization, including focus on the perpetrator (Itzin, Taket, & Barter-Godfrey, 2010). This may be all the more important for active substance users who may be less able to put in place safety strategies and who are more likely to live with a substance-using partner, vastly increasing the chances of experiencing physical or sexual violence (Cohen et al., 2013).

Service practitioners should also pay attention to the quality and safety of external support networks of women in treatment, as they can be both a source of burden and/or support. This is particularly important when delivering social and network-based treatment interventions (e.g. Copello, Orford, Hodgson & Tober, 2009) to women with IPA histories. Service user collaboration in the design and delivery of interventions is an important part of TIP and also provides safe and healthy ongoing support beyond time-limited treatments, something often lacking for this treatment group beyond 12-step affiliated groups (Najavits & Hien, 2013). It can provide another relational aspect of treatment so valued by women; building positive self-identity and promoting social action or 'survivor mission' (Herman, 2001).

TIP acknowledges how different forms of oppressions intersect with gender inequality and the role of inter-generational trauma experienced by communities subject to racism (Amaro, McGraw et al., 2005; Menzies, 2012). This approach may be particularly relevant to women from BME communities because mental health recovery frameworks lack acknowledgement of their experiences of racism and discrimination, potentially a significant cause of distress (Kalathill, 2011). Fowler & Faulkner's (2011) meta-analysis found that studies with higher proportions of Black and Hispanic women also showed larger effect sizes (Fowler & Faulkner, 2011). This suggests that approaches that adopt a more culturally aware practice, as illustrated by the WCDV sites, are effective for targeting the needs of BME women in recovery, as well as White women. This is important given the difficulty of retaining BME women in substance use treatment (Guerrero et al., 2013; King & Canada, 2004; Mertens & Weisner, 2000), and the fact that Black and Hispanic women in the WCDV study were found to be more severely disadvantaged in regards to economic and social life conditions compared to White women (Amaro, Larson, et al., 2005).

### **3.5.6 Other implementation considerations**

A number of other findings from this review regarding implementation are useful for the next phases of this PhD. Future trials should consider the most suitable practical methods for supporting women to remain in treatment whether this be childcare, logistical support, provision of meals and/or regular phone-calls to remind participants of treatment sessions. In considering

the delivery format, this review identified heterogeneity amongst the studies in terms number of sessions delivered but suggested shorter treatments may be superior for promoting higher treatment retention. A meta-analysis suggested that full dose Seeking Safety had an advantage over a 12 session dose in post-treatment drug and alcohol reduction, but not in PTSD (Roberts et al., 2016). These considerations need to be balanced with the practicalities and service delivery models in community-based substance use treatment services in England, particularly in the context of ever-increasing budget cuts (ACMD, 2017). It is also noteworthy that several studies involving past-focused components explicitly recommended a greater focus on case management in future studies (Foa et al., 2013; Mills, Teeson et al., 2012). For example, the study personnel in a trial involving prolonged exposure (Foa et al., 2013)<sup>35</sup> expended a greater amount of time and effort managing participants' crises during treatment than expected. Specifically, issues included the involvement of some female participants in prostitution to support themselves. Other studies involving exposure aimed at PTSD only, found that treatment of participants with multiple traumas, and those with greater social problems, focused more on addressing current crises rather than trauma memory (Ehlers et al., 2013). Therefore, because case management appears to be an important component in delivering integrated interventions to women it may be less about number of ancillary services provided, but rather identifying the ones that meet the specific needs of service users at the time.

Present-focused interventions reviewed in this study, were less likely to involve practitioners with psychology qualifications, compared to past-focused interventions. This is more reflective of the skills and qualifications of practitioners typically found in UK substance use treatment (ACMD, 2017). The modality of group-work is also congruent to current service delivery styles. Perhaps the accessibility of these interventions explains the strong adoption of Seeking Safety seen in the US treatment system (Capezza & Najavits, 2012) and its predominance in the trial literature (Najavits & Hien, 2013). However, it does appear that the delivery of wider TIP, and present-focused interventions of any kind, potentially require higher clinical skills than those found among

---

35 This study was excluded in this review due to low levels of female participants.

typical UK substance use treatment staff. Therefore, attention must be paid to selecting practitioners with the correct values and commitments and appropriate clinical knowledge and skills to treat PTSD.

### **3.5.7 The value of present-focused integrated interventions**

The studies included in this review contained samples of women with a wide range of PTSD symptoms, not only those meeting a clinical diagnosis, reflective of women in substance use treatment. Whilst the most recent systematic review of integrated interventions (Roberts et al., 2016) found no evidence for present-focused treatments, the results of this narrative review suggest that coping skills training focused on establishing external safety, emotional regulation, and building positive self-identity and relations with others, may well be the most appropriate treatment for some women. This is particularly the case for those with more severe baseline PTSD and substance use symptoms (Cloitre, Petkova, Su, & Weiss, 2016), and those facing other stressors who are not in a suitable place to explore traumatic memories in depth e.g., intimate partner violence, involvement in prostitution. The development of coping skills over time may help participants tolerate past-focused interventions to support memory processing should they need it (Hermann, Hamblen, Bernardy, & Schnurr, 2014). Greater relief is gained from PTSD symptoms through exposure work combined with CBT compared to CBT alone for certain subgroups (Ehlers et al., 2013; Mills, Teeson et al., 2012; Sannibale et al., 2013).

### **3.5.8 Conclusion**

This review acknowledges the complexity of delivering integrated interventions to women experiencing PTSD and substance use. Supplementary data analyses illustrate how an exclusive focus on average treatment effect risks overlooking the utility of present-focused interventions for certain subgroups, especially their role in targeting emotional dysregulation and providing longer focus on safety and stabilization strategies. A wider service response embracing TIP would focus practitioners on a safety-first approach. Only one study involved mindfulness as its principle component and the promising results found in relation to dissociation and emotional dysregulation means they warrant further consideration. Future research of integrated interventions should comprise both qualitative and quantitative measurement of potential intermediary outcomes

including differing coping skills, physical and emotional safety measures, negative cognitions, positive self-identity and emotional dysregulation.

The valuable learning from this systematic review provided information to inform the next phases of the PhD; narrowing the consideration of possible interventions to present-focused models. This is due to the focus on physical and emotional safety, and for pragmatic reasons, due to compatibility with the structure and staff skills found in community-based substance use treatment services. Of the present-focused models identified, Seeking Safety and TREM appeared to have the strongest evidence base in addressing PTSD and substance use among women, in terms of effectiveness and process evaluation to guide implementation. Therefore, these two models formed the focus in the remaining study phases.

## Chapter 4: Stakeholder Consultation

This chapter is an extended version of a journal article, which has been reviewed by Drug and Alcohol Review, and subject minor amendments, should be published in 2019, entitled:

*“We have to put the fire out first before we start rebuilding the house”*: UK Practitioners’ experiences of supporting women with histories of substance use, interpersonal abuse and symptoms of post-traumatic stress disorder.

This chapter comprises additional data from interviews with stakeholders from the USA, combined with the data from stakeholders in England featuring in the article.

### 4.1 Introduction

Comprising phase 2 of the study, this chapter involves qualitative research with stakeholders in the USA and England, who have experience of delivering integrated trauma-specific interventions (here after ‘*integrated interventions*’) to women that address PTSD symptoms and substance use. This phase builds on the systematic review by harnessing the experience and learning of stakeholders in order to understand the current practice in England, and gathering further implementation lessons from the USA, to inform the feasibility study in phase 4. This chapter will begin by recapping the current policy position in the UK and internationally, and then outline the objectives of the qualitative research. This is followed by a description of the methods before presenting the results and discussion, including implications for the next stages of the PhD study.

#### 4.1.1 International and UK policy

As discussed in Chapter 1, clinical PTSD guidelines in Australia and the USA (Australian Government, 2013; US Veterans Health Administration, 2017), recommend integrated trauma-specific interventions delivered within a staged treatment model focused on 1) safety and stabilisation, 2) trauma memory processing, and 3) re-connection. In the UK, up until very recently (November 2018), clinical guidance recommended a sequential model to PTSD treatment where SUDs are addressed first (NICE, 2005). Specialist PTSD treatments aligned to the staged treatment model are therefore inaccessible to the majority of those with recent histories of

substance use or active substance use. This may in part explain why in England, trauma work of any type with women experiencing substance use is in its nascence. Illustration and evaluation of practitioner experiences of integrated interventions and TIP is sorely lacking, with one exception, the evaluation of TIP within a women-only residential service (Tompkins & Neale, 2016). At the same time, UK substance use treatment guidelines promote the importance of TIP (DoH, 2017), however little is yet known regarding the practical adoption of this approach in England. Developing the capacity of substance use treatment services to deliver both integrated interventions and TIP is important because it provides a first line response to women with a variety of PTSD symptoms who would be ineligible for other services due to their substance use.

#### **4.1.2 The purpose of stakeholder consultation**

With such limited data on the current practice in England, it would appear pertinent to explore how practitioners here are addressing the overlapping issues of PTSD and substance use among women; their models and the challenges faced. It would also appear pertinent to consult practitioners and researchers in the USA, with years of experience implementing integrated interventions, in order to draw on their learning to guide the development of services here in England. Identifying the translatable learning from the USA is an important step for the design and delivery of the next phases of the PhD study. Funding was competitively awarded in order to facilitate a visit to the USA.

#### **4.1.3 Qualitative research study objectives**

The objectives of the stakeholder consultation were:

- 1) To explore in-depth how practitioners with a range of clinical disciplines working in services across sectors in England were addressing IPA, PTSD, and substance use in their practice with women;
- 2) To explore how practitioners were operationalizing TIP and the staged trauma treatment model, and the key considerations and challenges faced;
- 3) To explore the lessons learnt from stakeholders in the USA delivering or evaluating present-focused interventions, with a focus on implementation and contextual factors to inform phases 3 & 4 of the PhD study.



## 4.2 Method

### 4.2.1 Theoretical assumptions

Qualitative research is the most suitable method for attempting to make sense of, or interpret phenomena, by understanding the meanings that people bring to them (Denzin & Lincoln, 1994). It is the best method to answer the research objectives with sufficient breadth and depth. Critical realist epistemology (Bhaskar, 1975) guided the approach to the qualitative research, as outlined in Chapter 2. The data collection adopted some aspects of realist interviewing (Manzano, 2016; Pawson & Tilley, 1997); which was originally developed as part of realist evaluation methods that elucidate context-mechanism-outcome combinations to explain how, why, and for whom a particular intervention is working (Pawson & Tilley, 1997). With this approach, the interviewer comes prepared with theories about how or why programmes may or may not work and asks for the views of the interviewee. The interview thus acts as a vessel to confirm, falsify, modify, and refine the researcher's theory (Manzano, 2016). An example of a theory discussed in this study was the claim that ongoing victimisation impacts on a woman's ability to engage with services (see Appendix 9 Topic Guide for more theories). The interview facilitates a 'teacher-learner relationship', with the researcher and interviewer moving between both these positions (Pawson & Tilley, 2004, p.12). So, whilst there is a collaborative approach to theory development, the method is realist at heart, in that the interview is searching for evidence of 'real phenomena and processes' (Maxwell, 2012, p.103), based on the experiences and views of experienced practitioners.

In this study, I believe this interview technique also helped unveil participants' philosophies, values, and assumptions underpinning their approach to service delivery. This approach also provided opportunity to better expose my positionality, as a feminist researcher whose experience working in the domestic and sexual violence (DSV) sector has guided my theoretical perspectives and social critique related to the topic matter, something also known by some of the stakeholders.

Unlike realist evaluation, I did not aim to elucidate clear Context-Mechanism-Outcome constructions as part of the overall objectives of the PhD study. However, the identification of

contexts, core programme components, and potential 'mechanisms of action' that influence women's outcomes related to IPA, PTSD and substance use, were of interest. Adopting a realist approach for part of the topic guide appeared an appropriate and useful method of eliciting these from the stakeholders.

#### **4.2.2 Design**

This qualitative study involved a purposive sample of i) 14 semi-structured interviews with practitioners from substance use, IPA, and women's specialist criminal justice services in England; and ii) 11 semi-structured interviews with practitioners and researchers involved in delivering various integrated trauma-specific interventions for women in the USA.

#### **4.2.3 Sample selection**

##### **4.2.3.1 Interview Sample in England**

Practitioners in England working with women experiencing IPA, substance use, and a wide range of PTSD symptoms (full/ partial, undiagnosed/diagnosed) were invited by myself to participate in the research through a scoping email sent via online networks/listservs (n=9) through gatekeepers in relevant agencies (e.g. Public Health England, academic institutions) (n=6), and through my own contacts (n=12) (see Appendix 5 for inclusion/exclusion criteria and recruitment networks). Follow-up communication by myself took place by email or telephone with the 46 people who replied to the scoping email, in order to help further clarify how practitioners addressed all the co-occurring issues within a service. Of these, a number were immediately ineligible (e.g., based in other countries) or did not reply upon follow-up (n=8). Communication took place with the remaining others (n=24) to ascertain eligibility. Fourteen practitioners were then purposively selected to reflect a range of expertise, clinical disciplines, and service delivery models in England. Emphasis was placed on representation of those delivering integrated treatments, involving present and past focused interventions, as well as those delivering manualised interventions, which could be replicated in the phase 4 feasibility study. Moreover, a mixture of front-line practitioners and those at managerial/director level were sought based on the expectation that the former were best suited to identify core programme components, and the

latter to advise on wider contextual factors affecting service delivery (Manzano, 2016). Most of the 14 practitioners worked in the voluntary sector and half were clinical psychologists. Half of the practitioners offered group-work addressing wider mental health issues including PTSD, and five only offered one-to-one therapy. All UK practitioners supported women with a range of PTSD and substance use severity. More details of the sample are provided in Table 3, sec 4.3.1.

#### **4.2.3.2 Interview sample in the USA**

The visit to the USA focused on visiting services delivering present-focused integrated interventions with women who use substances, particularly TREM and Seeking Safety. The visit also provided an opportunity to collect data for the PhD through a series of semi-structured interviews. Firstly, direct email contact was made with nine Principle Investigators and/or intervention authors of seven different present-focused models used in the trials identified in the systematic review (Chapter 3), to ask for the contact details of the services with which they worked. Only services based in the North East of the USA were requested for logistical reasons. Replies were received from seven people who provided the contact details of nine services based in the states of New York, Washington DC, Massachusetts, and Vermont. Between them the services delivered TREM (Harris, 1998), Seeking Safety (Najavits, 2002), Relapse Prevention and Relationship Programme (Gilbert et al., 2005), and ICBT for PTSD (McGovern, 2011). Contact was then made with all those services delivering these interventions, except ICBT for PTSD because this was an intervention delivered on an individual basis (not group-work) and therefore not a consideration for the feasibility study. Eleven stakeholders from ten services were interviewed and more descriptors of the sample are provided in Table 4, sec 4.4.1

#### **4.2.4 Data collection**

Ethics approval was received from KCL (ref HR-16/17-4598); the South London and Maudsley (ref LRS-15/16-1921) and Camden and Islington (ref 204083) NHS Foundation Trusts (Appendices 6-8). All stakeholders were sent an information sheet in advance by email from myself, explaining informed consent, confidentiality, and data protection. The consent form also sought permission to use identifying information such as name, job-title, and organisation alongside any quotes. All US stakeholders gave written permission to be identified. Several

English stakeholders did not wish to be identified by name and therefore identification (ID) number, generic job title, sector and country were used as accompanying descriptors to quotes. Written consent was obtained before commencing all interviews, which took place at KCL between February and November 2016. All US participants were interviewed at their services, individually or in pairs, in May 2016. All interviews were audio-recorded and lasted 50-80 minutes. Unique IDs were assigned to all data and person identifiable data removed from transcripts.

Two different topics guides were used; one for researchers (USA only) and one for practitioners (USA & UK), although there was some overlap in subject matter (see Appendices 9 & 10). The topic guide used with practitioners' was structured in four parts comprising semi-structured questions to: 1) elicit contextual information about the participants' role in relation to the topic matter, and details of their service and service user profile; 2) explore views on key theories of change for improving outcomes for women with overlapping issues, and challenges to their work; 3) explore views on core components of TIP and trauma-specific models; and 4) explore views on factors which would aid implementation of any new intervention piloted. The topic guide used with researchers from the USA explored stakeholder views on: 1) the current state of the trial literature on integrated interventions, and 2) implementation and process related issues to inform the next phases of the PhD study. The topic guides were kept broad in order to respond to the particular specialism or expertise of practitioners, and also comprised theories for discussion. No pilot interviews were undertaken, however the topic guide for the UK interviews was adjusted slightly after the first few interviews (e.g., to introduce prompts for markers of TIP in section 4).

Not all agreed with the theories that I proposed, and it was interesting to hear other alternatives. For example, this excerpt is taken from the transcript of the interview with one practitioner from England, a psychologist delivering a group programme for women within a mixed-gender substance use service:

"KB: Here are some theories that I have picked up from the literature and I would be interested in hearing whether you agree or disagree, I am just going to put them out there. If someone is still being traumatised from a violent partner, or violence from gang activity, this may potentially interfere with their ability to access or engage with substance misuse or PTSD treatment.

Stakeholder: No, I don't agree with that. If the substance misuse service can respond to a client's presentation which is trauma then that shouldn't stop someone. It's not about a client not being able to engage with the substance misuse service, it's the service delivery or the model of the service may not fit in with what the client needs."

#### **4.2.5 Data analysis**

NVivo 10 was used to oversee the management and analysis of data. Thematic analysis (Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2006) was chosen to encompass both an inductive and deductive approach to code and theme development. This type of analysis also fits well within a critical realist approach in that it seeks to explore the meanings, experiences and the reality of participants (Braun & Clarke, 2006). A deductive approach was important for this study because I was influenced by the results of the systematic review (Chapter 3). Allowing for inductive analysis was also important in order allow identification of new concepts and phenomena only accessible by staying very close to the data, and which may not appear immediately relevant to the research questions (Braun & Clarke, 2006).

##### **4.2.5.1 Analysis of interviews from England**

The analysis of the interviews from England took place before those of the USA and focused on providing both descriptive as well as interpretive analyses in response to the following research question:

*"How are services from a range of sectors in England addressing IPA, PTSD symptom, and substance use in their practice with women. Specifically, how are practitioners operationalizing TIP and the staged trauma treatment model, and what are the key considerations and challenges faced?" (RQ1)*

##### **4.2.5.1.1 Familiarisation**

A pre-requisite start to any analysis is immersing oneself in the data; this began with the process of transcribing, and by reading and re-reading the final transcripts actively, noting any early ideas or concepts that came to mind for use later. This stage also helped to inform the development of an initial code-book.

#### 4.2.5.1.2 Generating initial codes

Firstly, I devised an initial broad set of codes, which were theoretically based deriving from the topic guide and concepts in the staged treatment model. Through re-reading transcripts, additional codes were also devised. Appendix 11 outlines this initial codebook which comprised 19 broad codes ranging from *intersectionality* and *service user profile*, through to *service model*, *working with victims of intimate partner violence*, and *partnership working*. The transcripts were then uploaded to NVivo 10 and the software was used to assign these 'codes' to segments of text selected as representative of the codes. The same section of text could be assigned to more than one descriptive code, for example descriptions of *general service model* also formed *important service attribute* and/or *mechanism of action*.

Next more systematic line-by-line coding was applied to the text assigned to the initial codes to create smaller coding units (sub-codes) (Rhodes & Coomber, 2010). These were more inductive in their nature in terms of labelling in a meaningful, clear and concise way a phenomenon observed in the data (Boyatzis, 1998). Examples of new sub-codes created were: 1) *External challenges* [Lack of service integration, funding challenges, access to mental health services, traumatisation by services, rejection of substance users]; and 2) *Important service attributes* [Caring and Warm, Flexible, gendered response, holistic, long term work, non-judgemental, strengths-based practice, non pathologising]. Four of the transcripts (28%) were independently coded by a second researcher (KT or GG) and cross-referenced with my codebook; at least 80% inter-rater agreement was found, that is to say at least 80% of the codes of the second researchers matched mine. Separate meetings were held with the second raters to discuss and revise coding. The discussions focused on: 1) identifying where there were clear alignments in codes i.e., where the label assigned to the code was essentially capturing the same phenomenon; for example, KT's code of *Acknowledging strengths/positives* was deemed similar in nature to my code of *Strengths-based practice*; 2) where codes could be merged, for example, GG's code of *Sustainability* was merged under my code of *Funding challenges*; and 3) where new codes were needed, for example, *Neurobiology of trauma* and *Mental health awareness*. At this point it was necessary to return to NVivo and make the requisite changes to the coding framework, review the original transcripts to check if the assigned text were still appropriate for the newly

merged/renamed codes, and apply the new codes to the text where relevant. Records of amendments were made and saved in NVivo.

#### 4.2.5.1.3 Identifying and reviewing themes

Surveying the full list of sub-codes, it became apparent that there was some repetition, for example, sub-codes in the text assigned to *Important service components* were similar to *Current service model*. Therefore, some were merged and/or recoded. At this point the initial set of broad descriptive codes (first outlined in Appendix 11), became redundant and re-groupings of the sub-codes took place under potential themes, suggesting potential 'patterns' in these data. For this process a series of maps and diagrams were drawn by hand, which underwent a series of iterations. Figure 7 provides an example of an initial map. Following the guidance of Braun and Clarke (2006), themes were examined to assess their appropriateness in terms of internal homogeneity (data within themes should cohere together meaningfully), and external homogeneity (clear and identifiable distinctions between themes) (Patton, 1990)

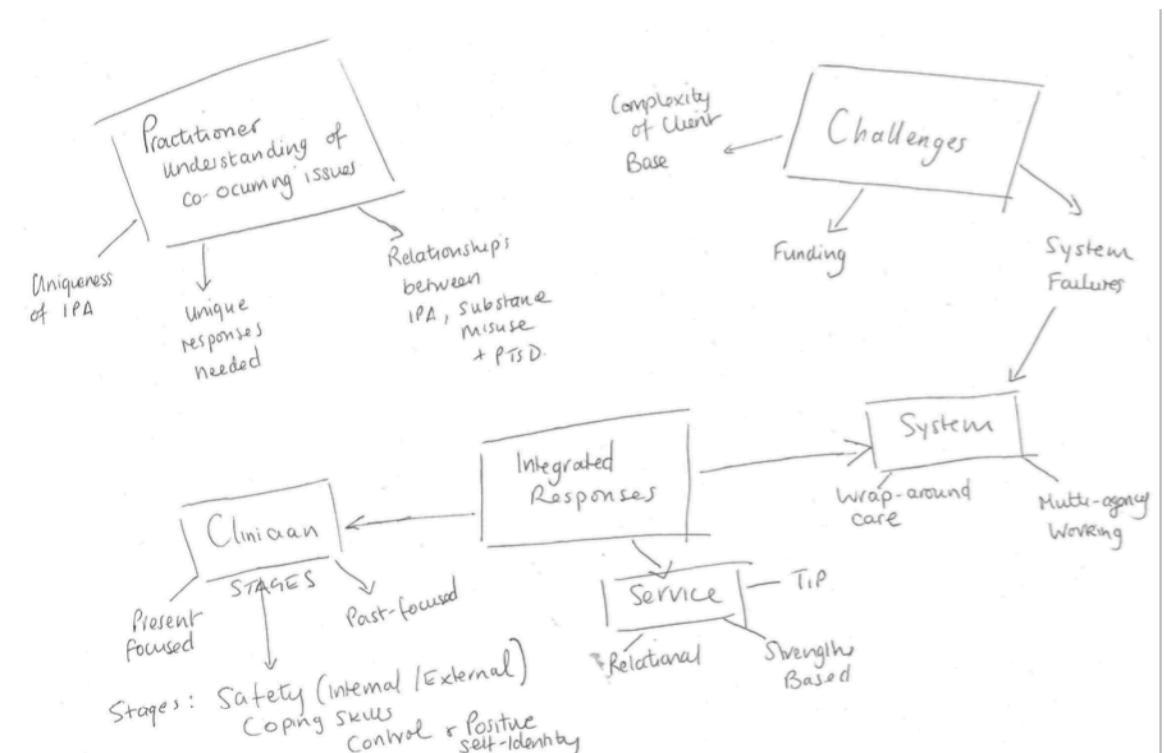


Figure 7: Early thematic map used to support analysis of the stakeholder interviews from England

#### 4.2.5.1.4 Refining themes and finalising the thematic framework

This stage required returning to the text assigned to each theme to assess its 'fit' and to assess for text that should be moved elsewhere, recoded or discarded altogether. Similarly, the lack of fit may signify the need to reject a theme or reconceptualise, merge, or fit under another theme as a sub-theme. For example, in Figure 7 above it became obvious that much of the data and codes assigned under *Challenges* actually belonged as sub-themes under *System*. Transcripts were then revisited to explore for similarities and differences in accordance to clinical discipline/service specialisms. This revealed several areas: views on individual versus group-work, views on exposure work, beliefs about statutory versus voluntary sector services, and the role of psychologists. At this stage the process moved from only being descriptive to developing a more abstract and interpretive understanding of how the text, codes, themes, and sub-themes related to each other and may fit within wider theories (Fereday & Muir-Cochrane, 2006).

#### 4.2.5.2 Analysis of US Interviews

The analysis of the US data started with the *familiarisation* stage using the process of transcription and reading over the transcripts. In comparison to the data from England, a light touch approach to analysis was deemed appropriate due to the extensive literature already available about practitioner experiences of delivering TIP and trauma-specific interventions in the USA, identified in the systematic review (e.g., Heckman et al., 2004; Markoff et al., 2005; Cadiz et al., 2004). As such the analysis was highly deductive in nature and involved first applying a pre-defined code book closely aligned to a more narrow and specific research question, and involved descriptive analysis only. In this way the analysis identified relevant practice implications for England, given that the structure and delivery of US healthcare services are different. The research question was as follows:

*"What are the lessons learnt from stakeholders in the USA delivering or evaluating present-focused interventions, with a focus on implementation and contextual considerations of relevance to phase 3 & 4 of the PhD study?" (RQ2)*



#### 4.2.5.2.1 Generating initial codes

All transcripts were uploaded to NVivo 10; and sections of text were assigned to the three broad codes of *Implementation considerations*, *Context* and *Research considerations* (Appendix 12). Therefore, data from the US interviews that did not fit within these broad categories were not analysed. The next phase involved revisiting the assigned text and re-reading the excerpts in order to devise more detailed sub-codes (Rhodes & Coomber, 2010). This was partially influenced by the prior analysis for example, the creation of a sub-code for *ongoing violence* (under *Context*) was influenced by the fact this featured in the previous data analysis. However, there were also new sub-codes identified for example, *12-step* and *Grant-funded*. Next, all the assigned text was revisited and the more detailed set of codes were then applied, with some text assigned to more than one code.

#### 4.2.5.2.2 Identifying and reviewing themes

Upon reviewing all the sub-codes, I began generating ideas of how these could be grouped together in themes and sub-themes sufficiently different from each other and sufficiently similar internally (external and internal homogeneity) (Patton, 1990). As with the interviews in England, the original deductive codes first used to categorise data became redundant. It also became apparent at this stage that some of the proposed themes were aspects of *Context* but had implications for *Implementation* and so the divide between the two was no longer helpful. For example, the theme of *Diversity* included sub-codes relating to the client group and also the adaptations to written material that stakeholders had made in their implementation of the intervention.

At this stage I was also aware of the similarities and differences between the stakeholder responses in England and the US and generating potential ways to 'triangulate' the data in the presentation of the results. Similar themes across the data sets were: 1) views on the staff skills and experience required, 2) the importance of multiple wrap-around services, and 3) the divergent views on the necessity of TIP. As such some themes were repeated when presenting the results for the two research questions, with the concordant and divergent views highlighted. The results from both research questions are then examined together in the discussion.

### 4.3 Findings: research question 1

*“How are services, from a range of sectors and clinical disciplines in England, addressing IPA, symptoms of PTSD, and substance use in their practice with women. Specifically, how are practitioners operationalizing TIP and the staged trauma treatment model, and what are the key considerations and challenges faced?”*

#### 4.3.1 Description of stakeholders from England

The majority of the 14 practitioners interviewed described working with women with suspected full or partial PTSD symptoms but who had not been diagnosed. Whilst the language of TIP was not used widely, the operationalization of some components was visible. Psychologists most commonly discussed the staged treatment model, however, all practitioners described core elements of their practice that was highly complementary with this model. Familiarity with the manualised integrated interventions, discussed in Chapter 3, varied; and psychologists delivered most interventions. One psychologist used Compassion Focused Therapy (Lee, 2012), which is not an integrated intervention, however she used her experience to integrate substance use. Two therapists based in the DSV and Substance use/CSA services had developed their own in-house models, one of which included the delivery of past-focused components as part of a staged model. For all these services, the delivery of the ‘psychological therapy’ was only one aspect of their trauma model.

Analysis of the practitioners’ responses identified three interlinking themes: *tailored practice* focused on safety and stabilisation, underpinned by practitioners’ *philosophical approach*, and a *wider systemic response*. These, along with their sub-themes, are represented in Figure 8 and described below.

Table 3: Final sample of the 14 stakeholders interviewed from England

<b>Job title</b>	<b>Sector</b>	<b>Primary Service specialism</b>	<b>Models used</b>
<p>Clinical Psychologist (n=7)</p> <p>Domestic violence (DV)/Complex Needs worker (n=2)</p> <p>Counsellor (n=1)</p> <p>Service Director/Manager (n=3)</p> <p>Project Manager (n=1)</p>	<p>National Health Service (NHS) Mental Health (n=2)</p> <p>Community Interest Company (CIC) (n=1)</p> <p>Voluntary "Not-for profit" sector (n=11)</p>	<p>Substance Use (n=6)</p> <p>Criminal Justice Service (CJS) (n=2)</p> <p>Domestic and Sexual Violence (DSV) (n=5)</p> <p>Substance Use &amp; Child Sexual Abuse (n=1)</p>	<p>Seeking Safety (Najavits, 2002); (n=4)</p> <p>TREM (Harris &amp; Fallot 2001), (n=2)</p> <p>Beyond Trauma (Covington, 2000) (n=1)</p> <p>Compassion Focused Therapy (Lee, 2012) (n=1)</p> <p>Eye Movement Desensitisation and Reprocessing (EMDR) (Shapiro, 1998) (n=4),</p> <p>Trauma Focused Cognitive Behavioural Therapy (TF-CBT) (e.g. Ehlers &amp; Clark, 2000) (n=2)</p> <p>In-house models (n=2)</p>

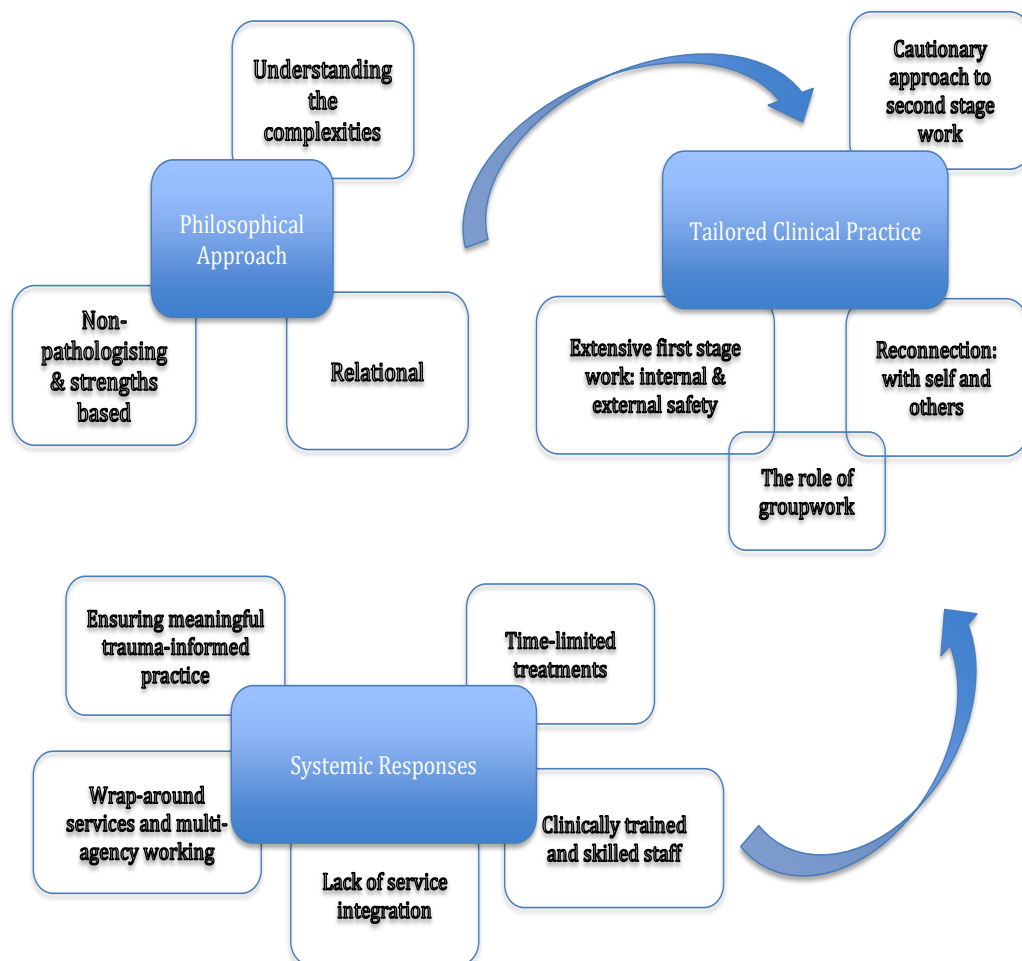


Figure 8: Thematic mapping related to practitioner experiences of providing care to address interpersonal abuse, PTSD symptoms, and substance use among women in England

### **4.3.2 Philosophical approach**

Regardless of clinical discipline or service specialism, all practitioners eschewed the traditional medical model focused on women's deficits and pathology, in favour of a strengths-based and relational approach. This centred on understanding the complexity of how IPA, PTSD symptoms, and substance use are interlinked.

#### **4.3.2.1 Understanding the complexities related to the co-occurring issues**

Practitioners in England discussed working with a client group experiencing high levels of multiple and repeated IPA over their lifespan and co-occurring mental health concerns. Many described their clients as having 'Complex PTSD' symptoms. Several practitioners working in substance use services also described a cohort of women with offending histories, removal of children, and involvement in prostitution. Most offered up conceptual frameworks related to self-medication; the use of substances to cope with PTSD symptoms and the wider stresses of IPA:

"All my clients said they started drinking because they couldn't stand the situation. They use it as an analgesic, and not only in a physical way also as a way of evading reality so they don't have to manage the anxiety of the stress, or any kind of uncomfortable feeling." (01UK, DSV worker, voluntary, substance use)

Several practitioners referred to substance use lifestyles that increase exposure to people who perpetrate further abuse. Specialist DSV practitioners also described the perpetrator's role in encouraging substance use to gain complicity, or in grooming processes, particularly for young women. Barriers to engaging and retaining women in support services included women's intimate partners sabotaging their efforts towards sobriety, women's own internal feelings of self-blame and struggle to trust others, and the neurobiological impacts of trauma impacting on their cognitive abilities e.g., remembering appointments or safety plans:

"Ongoing abuse impacts on the ability to engage with services, more women start to believe there is fundamentally something wrong with them as a person which then kind of reduces their ability to fully engage..." (02UK, Complex Needs Worker, Voluntary, DSV)

Several practitioners described the implications of failing to understand substance use within a self-medication model:

"If they have PTSD as well, what's going to happen if you potentially treat the alcohol abuse through detox and rehab and they go away... you are going to get a resurgence of the PTSD, and that could absolutely cause a relapse that ends their detox, it's a waste of funding, waste of the clients' time. It's reinforcing to them the fact that 'I can't do this'." (11UK, Psychologist, NHS Mental Health, Substance Use)

#### **4.3.2.2 Non-pathologising and strengths-based approaches**

Several practitioners spoke explicitly about the importance of reframing mental health symptoms and substance use as understandable responses to traumatic experiences:

"For PTSD I don't even like the 'D' because actually you are getting into those diagnoses, it's actually post-traumatic stress, because that makes sense rather than giving that 'D' because with that you are saying its abnormal. But actually, it's quite normal to experience that." (04UK, Psychologist, voluntary, substance use)

Others stressed the need for accepting a woman's individual recovery journey and the impact of her external circumstances. For example, avoiding blame towards women living with an abusive partner for not being ready to address their substance use. As one practitioner said,

"We wouldn't be expecting hostages to be improving their mental health." (09UK, Psychologist, voluntary, DSV)

Such philosophical approaches necessitate strengths-based practice, focusing on the resilience, survival skills, and internal capacities, rather than 'deficits'. This was a common theme in practitioners' descriptions of their service models:

"I don't talk about dysfunction, I don't talk about what's normal, it's really important that the women I work with know that I know their brains are amazing, that they do these things because they help them to survive." (08UK, Psychologist, voluntary, DSV)

#### **4.3.2.3 Relational responses**

Practitioners described practices that offered choice, flexibility and facilitated women's agency, key components of TIP:

"We don't refuse people either, so if she has been missing for 4 weeks because, I don't know, she has been off on a bender and comes back on the 5th week, the fact that she has been brave enough to walk through the door, we say come in." (14UK, Service Manager, voluntary, substance use)

For many, this approach was imperative to building strong therapeutic alliances between staff and clients:

"It's really important to me that our service is really responsive, it's important to the staff, they will do their utmost to respond to people as they present...The key point is how people make a relationship with their key-worker, it's all relational isn't it?" (05UK, Service Director, Voluntary, Substance Use)

Providing this level of flexibility, for example with missed appointments, was seen as an advantage of voluntary sector services over statutory mental health. Client advocacy was also deemed a strength of the specialist women's sector whether it involved challenging an inappropriate diagnosis with mental health services or facilitating women's access into refuges:

"Within the NHS, within a clinical team... you are not gonna get your clinicians that are going to pick up the phone and advocate for you but actually in the voluntary sector we do quite a lot of that, then we come to the bit where we actually start to look at therapy." (04UK, Psychologist, voluntary, substance use)

However, not all agreed:

"I don't necessary fall into the thinking that NHS is not very good or all women's [voluntary] services are great, it comes down to individual clinicians." (08UK, Psychologist, voluntary, DSV)

There were mixed responses to the proposed theory that women experiencing ongoing victimisation e.g., intimate partner violence, are less able to engage in treatment. Whilst most described the challenge of abusive partners sabotaging treatment, several practitioners, from across disciplines, also reframed the problem as non-gender responsive services. Instead they described how their service aims to meet women's immediate and practical needs, driven by the philosophical approach just described.

### **4.3.3 Tailored clinical practice**

The philosophical approach described previously was instrumental in driving the service responses of the practitioners, particularly in terms of a 'safety-first' approach.

#### **4.3.3.1 Extensive first stage work**

Regardless of clinical disciplines, sector or service specialisms, all practitioners used the language of 'safety' and 'stabilisation,' to describe their core work. These are central concepts in the first phase of the staged treatment model for PTSD. All practitioners stressed the lengthy and complex process of promoting internal and external safety when working with women, particularly those facing ongoing safety risks.

##### *4.3.3.1.1 External safety*

This practitioner explained the myriad of external safety risks that women face:

"So, for a woman using substances, there are going to be issues of external safety whether it's from a partner or from other users, or from her pimp, there are risks if you get very drunk a lot someone may well take advantage of you and sexually assault you and rape or rob you."(03UK, Project Manager, voluntary, DSV)

Detailed safety planning, which incorporated risk relating to substance use as well as risk from others, formed a crucial part of the first stage work:

"I can work with her around safety planning needs, she probably has learnt her own safety planning mechanisms, but really it does take talking through them, what are they, so they are also ingrained. Then giving options." (04UK, Psychologist, voluntary, substance use)

##### *4.3.3.1.2 Internal safety*

Providing psycho-education about the theory of self-medication was a key ingredient for promoting internal safety relating to emotional regulation and symptom stabilisation:

"I think having a story about the reason you are using substances, how you started using substances to manage your emotions. That really helps them, it just takes away that stigma associated with having used." (13UK, Psychologist, NHS Mental Health, Substance use)



Practitioners with more formal clinical training described the importance of educating women on the neurobiology of the traumatised brain:

“If someone is using alcohol to knock themselves out at night to stop the memories, to stop the nightmares, we have to quickly tell people ... the way alcohol works on the Central Nervous System...so the very thing that the client thinks is helping them, is maintaining the PTSD symptoms and the sense of current threat.” (11UK, Psychologist, NHS Mental Health, Substance Use)

Several practitioners, most notably in the DSV services, highlighted the importance of taking a gendered approach, in terms of providing information on prevalence and tactics of abusers in order to redress the internalisation of responsibility, blame, and shame:

“You are trying to unpack the messages from society, from the perpetrator, your own internalised messages and then the truth.” (06UK, Clinical Services Director, Voluntary, DSV)

Regardless of service specialism, many practitioners used a range of cognitive, behavioural and body-based techniques to help women achieve stabilisation in regulating emotions, managing symptoms and substance cravings. Those with more clinical training described providing women with a choice of grounding and self-soothing strategies. These included safe-place visualisations, breathing techniques and sensory-based tools such as essential oils. Other stakeholders talked about the importance of bodily self-care e.g., identifying states of hunger and thirst, or developing better sleep hygiene. Although not framed as PTSD interventions, some described a wide range of complementary therapies offered in their substance use services such as Tai-chi, yoga and massage:

“We can’t forget that fact that most experiences of violence involve an attack on the body so we if we don’t really heal the body, we will miss that.” (06UK, Service Director, voluntary, DSV)

Practitioners talked about the positive impact of such techniques, providing evidence for both the self-medication theory and confirming how substance use stabilisation then supports women to use safety strategies within unsafe relationships:

“When they can manage the trauma symptoms, they find that their relationship to substance use shifts.” (13UK, Psychologist, NHS Mental Health, Substance Use)

“If you can bring them back to that phase of stabilization they will be able to use the safety plan.” (04UK, Psychologist, Voluntary, Substance Use.)

#### **4.3.3.2 The role of group-work**

There were disagreements among practitioners about the sequencing of individual therapy and group-work. A number of the practitioners based in DSV and mental health services believed one-to-one therapy should be undertaken first in order to address individuals’ negative sense of self and trust which makes group-work challenging. Others were clear that any discussions of trauma would be destabilising in a group setting. One practitioner running TREM groups found that women with more severe substance use were more likely to drop out, due to the intensity of the topics focused on abuse. She instead advocated for teaching emotional regulation skills in the early stages of group-work, avoiding the trauma narrative; a point supported by others:

“We do use the words, tools, self-care, those kinds of things, so we deal with the emotions... but not going into the story; that will be with your individual counselling.” (10UK, Senior Counsellor, Voluntary, Substance Use/Child Sexual Abuse)

However, there was also a lot of support, from practitioners across all service specialisms, for the power of group-work in reducing social isolation and shame:

“I found that the group-work was much more effective at leading to change, in terms of symptom management, and the women being able to come to terms with why they were behaving the way they were, because the constant I heard from women was that I am crazy, there is something wrong with me, I can’t control myself, and being able to have those connections, I found those very powerful.” (12UK, Psychologist, CIC, CJS)

#### **4.3.3.3 Cautionary approach to second stage work**

Several practitioners delivered “past-focused” PTSD interventions, incorporating second stage work to reprocess intrusive memories, for example Eye Movement Desensitisation and Reprocessing (Shapiro, 1998). Noticeably, those undertaking such work had more formal qualifications in psychology but were based in a range of services specialisms, including substance use treatment services. However, all were very clear about the need for tailored

approaches and caution when delivering these treatments. This did not necessarily require full abstinence from substances but involved extended preparation work as part of a wider staged treatment model:

“I think that it takes people who are using substances a bit longer to be ready to do the trauma processing so it’s more about the psycho-education, symptom management, and compassion.”  
(13UK, Psychologist, NHS Mental Health, Substance use)

The type and severity of substance use, individual beliefs associated with it, emotional dysregulation and current external safety threats all influenced practitioner decisions to proceed with this component of therapy. For example, one psychologist working in a substance use service stated that only a 1/4 of clients would be deemed suitable, and only because of the specialist expertise of the service. All stakeholders were clear that it is unsafe to do memory processing with women still being re-traumatised through IPA:

“I wouldn’t be doing any work on intrusive events at that stage... another metaphor that I use is about the house being on fire and we have to put the fire out first before we start rebuilding the house.” (09UK, Psychologist, Voluntary, DSV)

However, caution was also warranted for women who were no longer at risk:

“She is now doing the memory work, but that has taken 25 sessions... we couldn’t move forward...because she was still living in the flat where she was raped, so we had to deal with those trigger experiences. It would have been unsafe and unethical to have taken her to the memory work.” (11UK, Psychologist, NHS Mental Health, Substance Use)

#### **4.3.3.4 Reconnection with self and others**

All practitioners discussed the importance of activities to support women’s transition from a world schema based on their sense of self as ‘mad or bad,’ to one of positive self-identity rooted in a healthy social community. Whilst not explicitly recognised as such by all practitioners, this approach mirrors ‘reconnection’ found in staged trauma treatment:

“Once people go through all these therapeutic interventions, there is still something about still feeling lost because they almost don’t feel that they still have purpose, because they don’t have that sense of opportunity.” (02UK, Complex Needs Worker, voluntary, substance use)

This aspect of treatment was particularly important for those with more complex PTSD symptoms:

“When we talk about complex PTSD then there are things that are not covered within the simple one. One is view of self, so there is making sense of why did they do that to me... but getting with those feelings of ‘I am bad’, dealing with the deep shame, and feeling, and it’s something that gets re-visited at different stages of therapy.” (09UK, Psychologist, voluntary, DSV)

Encouraging women to attempt new and meaningful activities to help ‘*reclaim her life*,’ also featured heavily in practitioners’ models of working. Several substance use practitioners discussed the importance of providing social activities, access to volunteering, and employment skills training as part of later stages of their general treatment model. Peer support was also highly valued in these services:

“We try to reflect aspects of treatment that are pro-social and create networks for women, communal meals, partnership dance project, phase two activities about women moving on and accessing education in the community or volunteering.” (05UK, Service Director, voluntary, substance use)

Similarly, the DSV services stressed the importance of creating safe support networks for women and providing social skills to help build and strengthen healthy relationships. Illustrating the non-linear nature of the staged model, some practitioners encouraged these activities following a programme of therapeutic work, but others introduced these components early on as part of stabilisation and symptom management. Notably, this component needed to continue long after the formal ‘therapy’ had ended.

One practitioner spoke about the importance of a women-only service in recreating positive self-identity for women:

“Something about the fact it’s run by women that actually feels like women run things, women can do all this, I think one of the really big things is about women’s identity.” (UK05, Service Director, Voluntary, Substance Use)

#### **4.3.4 Systemic responses**

##### **4.3.4.1 Lack of service integration**

Almost all practitioners, across all sectors and services specialisms, highlighted systemic problems within their own, and others', service-delivery models for women with multiple support needs. This focused particularly on lack of service integration, which made partnership working challenging:

"The system is not set up to work with the women...mental health services saying, 'she needs to be stable' and drug and alcohol services saying, 'we can't stabilise her cause it's her mental health'. And then domestic violence services saying, 'she has never engaged with substance use or mental health services, so we can't engage with her'." (02UK, Complex Needs Worker, Voluntary, DSV)

##### **4.3.4.2 Time-limited treatments**

Several practitioners raised the issue of funding cuts resulting in the commissioning of time-limited substance use treatments and lengthy waiting lists for mental health services:

"They [community mental health team] will not see someone who has not been abstinent for 3-months, even if they do see someone there is a 6-month waiting list after an assessment." (11UK, Psychologist, NHS Mental Health, Substance use)

The focus on short-term treatments was viewed as counter-productive and inefficient, particularly in relation to substance use, given the propensity to relapse, often precipitated by typical life stressors:

"Usually there is some crisis that precipitates them coming to see you [again], they've been arrested, took an overdose, been in A&E, put their child at risk, and that costs a huge amount of money, but actually if we just kept on with people a bit longer, it would probably be a bit more cost effective. But everyone wants you to talk about how you can do something, it won't take very long, and it will be effective." (05UK, Service Director, Voluntary, Substance Use)

#### 4.3.4.3 Wrap-around services and multi-agency working

The services differed in the value they placed on providing access to ancillary services. Many practitioners, situated primarily in the voluntary sector, described their service as 'holistic', offering a range of services including mindfulness, alternative therapies, and several different types of group-work such as emotional wellbeing and DSV. Several services operated as a 'community base,' somewhere to,

'come and feel safe and have a cup of coffee and free sandwich.... where they can get lots of needs met, rather than having to go out to all these strange places and get lost in appointments and letters.' (07UK, Psychologist, voluntary, CJS)

All practitioners identified the importance multi-agency working for establishing physical safety and supporting therapeutic work:

"That was crucial in the intervention, that MARAC (Multi-Agency Risk Assessment Conference) referral and working with the Independent Domestic Violence Advisor. They were great cause they could do things that I couldn't do, go around there to see her." (13UK, Psychologist, NHS Mental Health, Substance Use service)

"I had good links with her rehab and with her parole, and probation and I think having built up that network around her we could do the trauma work." (08UK, Psychologist, voluntary, DSV service).

Once again, the relational approach described previously as being key to engaging women, extends itself to cross service partnership working, especially in the face of the systemic problems in the provision of joined up services. Several practitioners delivering therapy identified a need for a support/advocate in their clinical service in order to facilitate effective case management:

"That external chaos, they are in poor housing, they are experiencing poverty, they are multiple disadvantage and adversities, we can't just work for that in one hour." (06UK, Service Director, voluntary, DSV)

This may reflect a gap in service design and funding which does not recognise the level of case management and advocacy required to support women with co-occurring mental health and substance use challenges, something discussed in more detail below.

#### **4.3.4.4 Ensuring meaningful TIP**

Several practitioners described the embedding of certain components of TIP across the entire organisation or team, but this terminology was not often used. Examples included: organisational development towards 'psychology informed environments' (DSV service); routine practice using validated PTSD assessments (substance use service); and DSV as standard agenda items in clinical meetings (substance use service). However, several practitioners critiqued attempts by their own or other services for attempting to develop 'tokenistic' TIP; expressing frustration at trauma interventions delivered within an environment that had not fully embraced TIP:

"It also includes an organisational philosophy, it's not just learning a little bit about trauma, and saying 'you are trauma informed'... I think it's buzz words, and people who don't understand it. I don't believe a short course in being trauma informed is good enough. I do think it has to be a real foundation." (08UK, Psychologist, Voluntary, DSV)

#### **4.3.4.5 Clinically trained and skilled staff**

The practitioners who were psychologists were of the opinion that formal psychology qualifications were necessary to deliver any integrated interventions, even those that are present-focused on safety and stabilisation such as Seeking Safety or TREM:

"This is my problem with domestic violence services, clinically trained could mean you have a person-centred counselling diploma. I think you need a clinical psychologist..." (08UK, Psychologist, Voluntary, DSV)

Others stressed that clinical qualifications were not always sufficient, emphasising the importance of understanding therapeutic group processes, trauma re-enactment, as well as practitioner self-reflection:

"You really need the skills to understand the process of trauma, be aware of your own biases, and working with women. How do you feel about women who remain in abusive relationships? Do you have your own trauma? Cause if you do then that better be worked on." (12UK, Psychologist, CIC, Criminal Justice)

The presence of psychologists operating in substance use and other specialist services for women appeared to be a key driver for embedding TIP organisational change and maintaining staff professional development:

“It works because we have psychologists there, and so I can create that narrative and keep it going with evidence, if you don’t have that regulation in the system or governance in the system, I don’t know how you create trauma informed services.” (11UK, Psychologist, NHS Mental Health, substance use)

## **4.4 Findings: research question 2**

*“What are the lessons learnt from stakeholders in the USA delivering or evaluating present-focused interventions with a focus on implementation and contextual factors of relevance to phase 3 & 4 of the PhD study?”*

### **4.4.1 Description of stakeholders from the USA**

Table 4 provides an overview of the sample. Six practitioners had experience of delivering and/or evaluating the Seeking Safety model, five were experienced in TREM, within both substance use and mental health services. Stakeholders also included the author of the Relapse Prevention and Relationship Programme, the co-author of TREM, and the author of Seeking Safety. One other clinician/researcher also had experience at delivering Concurrent Treatment for PTSD and Substance Use Disorder with Prolonged Exposure (COPE) (Mills, Teeson et al., 2012), a past-focused trauma-specific intervention discussed in the systematic review. The researchers were also experienced clinicians or social workers. All had conducted trials with female service users, or worked directly in services, based in the public healthcare system. These services operated in a similar manner to those found in England in terms of reliance on grant funding from government or philanthropy, adopting both harm minimisation and abstinence treatment models for substance use, and offering both mixed gender and women-only services.



Table 4: Final sample of the 11 stakeholders interviewed from the USA

Clinical Discipline	Principle Job Title	Sector/Service specialism	Present-focused models used
Licensed clinician (n=5)	Service Director (n=2)	Academia/Consultant (n=4)	Seeking Safety (Najavits, 2002) (n=6)
Clinical Psychologist (n=4)	Counsellor/Clinician (n=5)	Mental Health (n=1)	TREM (Harris, 1998) (n=5)
Social Work (n=2)	Researcher (n=4)	Substance Use (n=2)	Relapse Prevention and Relationship Programme (Gilbert et al., 2005) (n=1)
		Domestic violence (n=1)	
		Women's community service (n=1)	
		Housing (n=1)	

Analysis of stakeholder responses from the USA identified three over-arching themes: *opinions of delivering TREM and Seeking Safety, responding to context, and additional research considerations*. These, along with their sub-themes, are represented in Figure 9 and described below.

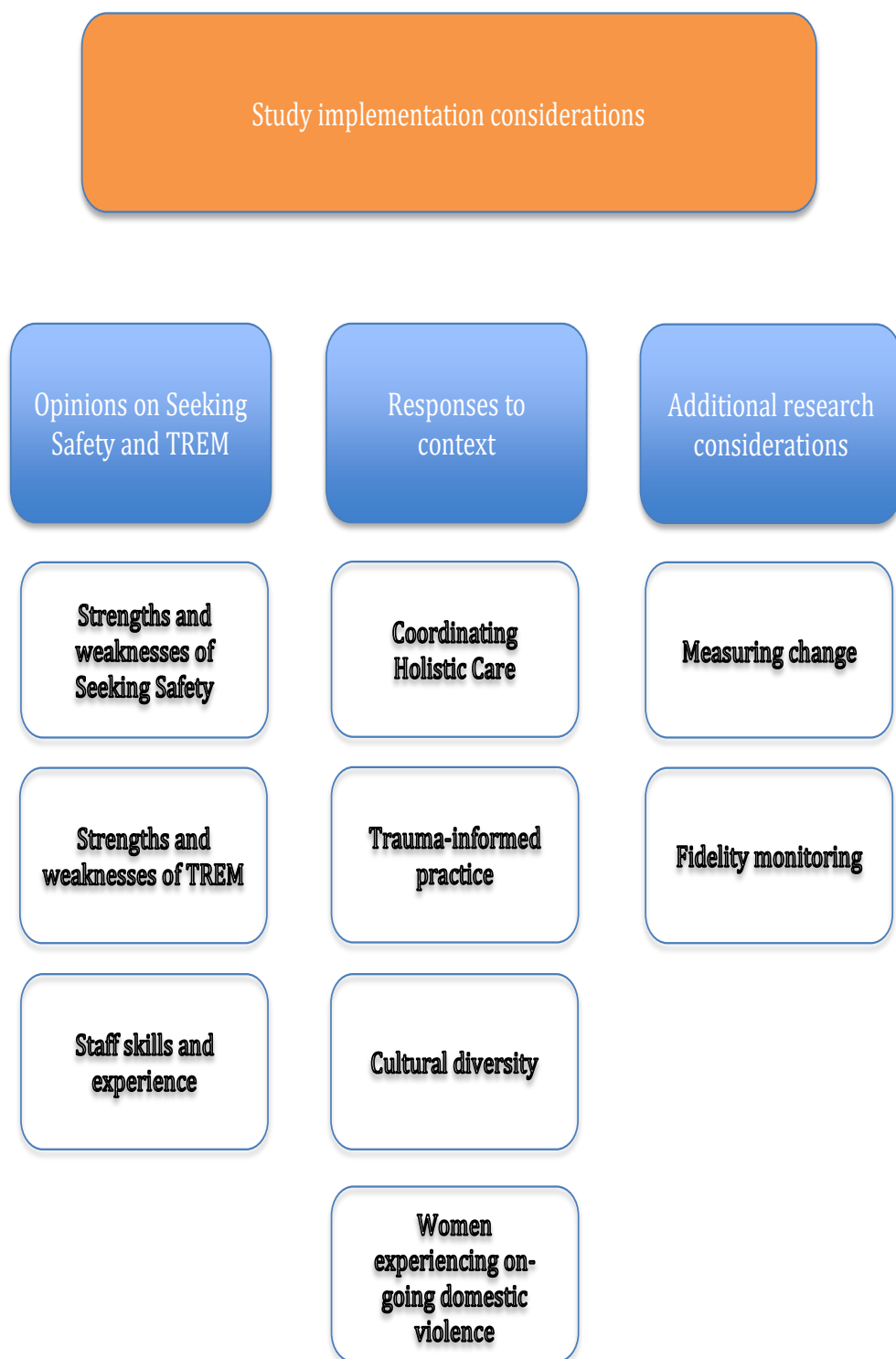


Figure 9: Thematic map of study implementation considerations derived from US stakeholders

## **4.4.2 Opinions of delivering TREM and Seeking Safety group-work**

Stakeholders expressed varying opinions about TREM and Seeking Safety, highlighting the benefits and limitations of both. The practitioners from England with awareness of these models also offered up mixed views and these have been incorporated into the following section. This is discussed below and summarised in Table 5, Chapter 5.

### **4.4.2.1 Strengths and weaknesses of Seeking Safety**

Amongst stakeholders with experience of delivering both models, there was a leaning towards the promotion of Seeking Safety over TREM. This was primarily because in comparison to TREM, Seeking Safety was designed for substance use services specifically, provides an explicit coping skill focus on substance use as well as PTSD symptoms, allows flexibility in the number and order of sessions, and was less likely to trigger traumatic responses:

“So, we piloted more than one thing... The structure of Seeking Safety is such that it feels incredibly safe, the way that it is designed is that it really holds, it's very rare for people to get triggered in that group, really rare, which we did not find was the case with TREM. Seeking Safety is the most structured, the least threatening.” (06USA, Service Director, Mental Health)

This echoes the feedback from one psychologist in England who believed Seeking Safety was more appropriate for those with more severe substance use, compared to TREM. Another psychologist from England, with experience of using Seeking Safety materials in her individual work with survivors of intimate partner violence, also spoke positively of the material:

“I think it sits very nicely with some of the feminist principles about choice, empowerment, the service user being an expert and yet giving people information. I like the hand-outs and the clarity, the structure of the work.” (09UK, Psychologist, voluntary, DSV)

However, other stakeholders described limitations to the Seeking Safety model. One psychologist in England praised the emphasis on safety, but found the lack of emotional focus too constrictive, describing it as ‘dry.’ Another US stakeholder described how she adapted Seeking Safety to incorporate more emotional regulation skills, and the importance of tailoring sessions:

“I have supervised a lot of students and learning about how to implement it [Seeking Safety] in domestic violence contexts and not, and you have to break up those sessions, one session could

be three sessions. Depends on the patient but there is too much information in all of these manuals... it really should be twice as long.” (03USA, Psychiatrist, academia)

Several of the US practitioners also made comments about the accessibility of some of the participant material, describing the language as too ‘high level’ for all groups of participants. However, those delivering TREM also described the need to repeat and re-iterate concepts and messages, reflecting the particular learning needs of this client base. A US clinician working with homeless people with serious mental illness found the material in Seeking Safety too cognitive based:

“Enough about the Seeking Safety wasn’t working that they would think twice about running it again. Needs lots of active work by facilitators. We used interns to help re-write the manual.” (02USA, Clinician, Housing)

Another US practitioner commented that Seeking Safety lacked a focus on gender, something that TREM does very well. However, this practitioner and her colleague also spoke positively about their attempts to translate the Seeking Safety manual into practice within substance use treatment agencies:

“For non-clinicians [for direct care staff who may not have Masters level degrees] it’s really easy to run, it doesn’t require you to have a huge level of skill or much knowledge because it’s right in front of you when you are doing the curriculum. It’s easy for people to lead and teach...” (06USA, Service Director, Mental Health)

However, one UK practitioner, who had reviewed the manual, disagreed with this:

“It will be interesting to see how Seeking Safety goes, interesting to run it, but that’s hard to translate into a group, this [holding up the manual] will take me forever, it isn’t actually there, it says it is, but it’s not, that was one of the reasons I set up my own.” (13UK, Psychologist, NHS Mental Health, substance use)

#### **4.4.2.2 Strengths and weaknesses of TREM**

A strength of TREM is the explicit programme design aimed at women:

“It’s built so clearly on the experiences of women, ‘What it means to be a woman’, it’s a very powerful session.” (09USA, psychologist, academia/consultant)

Practitioners with experience of delivering TREM praised it for its structure and consistency that helps women to feel emotionally safe at each session. Another strength is the flexibility to incorporate more alternative therapeutic exercises:

“There are suggested activities, but you could suggest a different activity, mindfulness or experiential, art therapy. We want there to be a different way for people to learn that is not just based on discussion so there is that freedom to add that in.” (04USA, Clinician, Mental health)

The intervention in its entirety contains 33 topics, which must be delivered in order over two phases. Like Seeking Safety, the guiding philosophy avoids detailed discussion of individual trauma narratives, however in the second phase, the intervention has specific topics on sexual, physical, and emotional abuse. An American practitioner now working in England discussed her experience in the American criminal justice system:

“By then I started to use the TREM model because I liked it better. Covington [author of Helping Women Recover] starts off with trauma right away. TREM has 5-6 sessions that gets women ready to talk about it right because it’s a very intimidating topic for women in that setting.” (12UK, Psychologist, CIC, CJS)

However, some stakeholders suggested that women needed to be a little further on in their recovery before starting TREM:

“Women really really need to be ready, because what they are going to hear from their peers or from the responses that are shared from the clinician is going to be triggering.” (05USA Clinician, Mental health)

#### **4.4.2.2 Staff skills and experience**

In similar vain to the practitioners from England, a theme in the narratives of the US stakeholders was the importance of strengths-based and collaborative practice, a key aspect of trauma-informed practice:

“We are collaborating with them, but it’s their goals, that is one of the key issues. Important that the agencies are on the same page with those goals, women’s goals have to be the top priority.” (09USA, psychologist, academia/consultant)

A researcher with substantial experience evaluating Seeking Safety echoed the points made above regarding their translational capacity:

“People can do it and you don’t have to be a highly educated PhD or Psychiatrist to do the intervention, you can train drug counsellors and people with a certain level of clinical ability and experience to do these groups, and mostly safely and without harm.” (03USA Psychiatrist, academia)

However, a note of caution expressed by one US stakeholder regarding staff skills reflects the dominance of 12-step approaches to treatment:

“I think when working with programmes, particularly with staff who are not as clinically trained as other staff, one of the things that we encounter is this AA or 12 Step recovery idea of telling people what to do and get them to do it and they’ll be fine, that doesn’t work with this.” (07USA, Psychologist, Substance Use)

#### **4.4.3 Responses to context**

##### **4.4.3.1 Coordination of holistic care**

In similar vain to the practitioners from England, those based in the US also discussed the importance of providing wrap-around services to address the range of support needs facing women. Most described a case management system that echoed that of the UK, drawing upon partnership working with many external agencies, social worker, mental health, housing and intimate partner violence:

“There are things that get in the way of people being able to make huge changes, that’s why with the case management services we are working with people to help them address all aspects of their lives so they can have stability to start working on the more interpersonal issues.” (04USA, Clinician, Mental health)

Reflecting the different healthcare systems in the two countries, US stakeholders discussed the importance of helping their clients to access primary healthcare services as part of their case management work:

“We see a lot of women who never go to the doctor or the dentist and that may be a crucial thing for them to get them some health appointments and things like that so sort of a ‘first-aide’ kind of approach.” (03USA, Psychologist, academia)

This same stakeholder also mentioned how obtaining a psychiatric diagnosis of PTSD played a role in opening up access to additional services and resources, which may again be reflective of the healthcare system in the USA, particularly related to insurance coverage:

“It is helpful to have a diagnosis as without it you can’t get money, resources, services, all these things, so if you don’t diagnose the problem, then that’s a problem too.” (03USA, Psychiatrist, academia)

Stakeholders involved in delivering several different trauma-specific group-work interventions described the importance of numerous psychosocial and health interventions offered in-house, or through referral to other services:

“A lot of women do, clearly, need supportive services, wrap around. The trauma group [Seeking Safety] is embedded in a full range of services, physical healthcare to family support process.” (09USA, Psychologist, Academia)

For example, one service, delivering the TREM group, also offered a comprehensive set of other group-work programmes related to leadership skills, parenting, and HIV prevention. Standard substance use relapse prevention was also offered, perhaps reflecting the fact that coping skills targeting substance use are not addressed so explicitly in TREM, in comparison to Seeking Safety:

“A lot of women are not just taking TREM, they need to be talking relapse prevention talking about triggers, coping skills in relation to substance use.” (05USA, Clinician, Substance Use)

Some stakeholders also suggested introducing alternative therapeutic activities such as expressive therapies or body-based components such as movement or mindfulness breathing:

“A lot of the research with trauma recovery is mindfulness, that mind-body connection, but that was not really as present when TREM was formulated.” (04USA, Clinician, Mental health)

“We created a therapeutic toy box that had for example, a slinky, squeeze balls, and gave them to people to use as grounding tool.” (02USA, Clinician, Housing provider)

“I have a diagnosis of ADHD [Attention Deficit Hyper-active Disorder] and sitting me down is like torture...I have had people come to my class and say one journey dance has done more for me than all of the therapy I have had combined in my entire life. One class.” (10USA, Service Director, Women’s Community Service)

Other stakeholders were highly supportive of body-based work but expressed a note of caution:

“People are potentially so uncomfortable with their bodies, that launching in for everyone to do yoga could feel dangerous depending on the timing, I would do it for the people who want to do it.” (03USA, Psychologist, academia)

“I think as part of stage 2 there is more of an ability to focus on the body. I think it can be very triggering for people in stage 1.” (08USA, Academia, Psychologist)

#### **4.4.3.2 TIP**

As an original author of the concept of TIP, one US stakeholder described the development of the practice within a large not-for-profit mental health service. This stakeholder stressed the investment in time and resources needed to instigate culture change:

“To implement this is about a culture change within an organisation and how it needs the administrated leadership...it takes a lot of time and energy for a service to become trauma informed. In terms of 2-3 years at least, to feel the cultural change...” (09USA, Psychologist, academia/consultant)

A practitioner working in this same service echoed this sentiment:

“I can be your therapist and be trauma informed and we have a great relationship, but if having to come into our waiting room and you're triggered or the people you interact with before you even see me, it kind of defeats the purpose of you seeing me because its already causing more distress and disruption than you not coming at all.” (04USA, Clinician, Mental health)

However, some US stakeholders interviewed expressed caution about the adoption of TIP, for different reasons. One stakeholder queried whether it was a necessary condition for the successful delivery of trauma-specific treatments, and another expressed concern about the poor implementation of TIP, mirroring practitioner concerns from England:

“I don't even like to use the term trauma informed anymore cause it's been so co-opted – now we are talking about full frame of someone's life. You can go on the full frame initiatives website.” (10USA, Service Director, Women's Community Service)



#### 4.4.3.3 Cultural Diversity

Stakeholders from the US described their service users as typically being low-income women, from diverse cultural populations, lacking healthcare insurance, and many of who were homeless. Although some services described their client base as being pre-dominantly African American, others, situated in less urban areas, highlighted how services struggle to engage diverse populations:

“People of colour don’t come to treatment, even though we have cultural specific programmes we often struggle to fill them, so we end up allowing other people to use them as we can’t leave the beds empty.” (06USA, Service Director, Substance Use)

Perhaps because of their experiences of working with diverse client groups, one of the stakeholders was critical of the tone of some of the material in Seeking Safety:

“They assume a certain income level. The tone of them is a bit preachy, “protect your body from HIV” and the activities promoted assume a certain level of privilege.” (02USA, Clinician, Housing)

Many US stakeholders commented on adaptations they had made to the programme materials to make them more meaningful to their client group. This related to simplifying the written hand-outs for people with learning difficulties, choosing more culturally specific quotes or case study examples, and translating their materials into Spanish. One stakeholder stressed the importance of employing staff that reflect the diversity of clients they support:

“A different direction these interventions and treatments need to take is to really let people who are mostly affected by the issues take the lead and tailor them to their own populations. So, all of our facilitators are Black or African American and our Project Director, clinical supervisor is Black or African American, it’s great.” (11USA, Academia, Social Work)

One stakeholder delivered their trauma-specific groups within a community-based service offering lots of activities, which she believed were important for being inclusive and building trust:

“... we create conditions where families come in together and have fun, they may not have money or ability.” (10USA, Service Director, Women’s Community Service)

#### **4.4.3.4 Women experiencing intimate partner violence**

Stakeholders held differing views about including women still experiencing intimate partner violence in the group-work programmes. Two stakeholders working at the same service expressed views that the Seeking Safety group could incorporate women facing ongoing risks. They discussed at length how discussions in the group could be tailored to discuss safety:

“... so if we are talking about safe choice making then someone [facilitator] might use that [safety planning], “So he is starting to do this so now is it safer for you to be in the living room or the kitchen.?” (USA06, Clinician, Substance Use)

However, one researcher stated that her trials of both present and past-focused interventions, which have included Seeking Safety, have excluded women known to be experiencing intimate partner violence. Among the stakeholders delivering TREM, there were also mixed opinions. One stakeholder described how her service wanted to make the intervention as inclusive as possible:

“We believe they need the intervention to address the problem, telling them they can’t do it until they get out of it [relationship] when we think doing the group may help them feel empowered to get out of a relationship.” (04USA Clinician, Substance Use)

However, another practitioner explained that because the group grows in intensity as the weeks progress, covering topics of sexual abuse and physical violence by weeks 12 and 13, it may not be appropriate for those still actively being traumatised:

“If they have disclosed trauma in the assessment, we suggest they may want to wait a month or two and find an outside therapist. I don’t believe it’s appropriate for them to be in the trauma group if they have had most recent trauma.” (05USA, Clinician, Substance Use)

The author of an intervention specifically targeting victims of intimate partner violence with active substance use described a different client group compared to Seeking Safety or TREM. She described the strengths of her intervention as the overt focus on safety planning, problem solving, and building safety social support. However, she acknowledged the limited focus on PTSD symptoms, and reflected on this as an area for improvement:

“I would probably have a stronger focus on the PTSD piece because I do think it does play, the cardinal symptoms, of putting women at ongoing risk in terms of intimate partner violence, the

dissociation. I think targeting those symptoms at least making sure we are getting women into treatment for that piece I would improve that piece.” (11USA, Academia, Social Work)

#### **4.4.4 Additional research considerations**

##### **4.4.4.1 Measuring change**

Several US stakeholders stressed the importance of noting intermediary changes that may eventually lead to remission of PTSD symptoms or substance use for example, fewer hospital admissions, social connection, and stable housing. Several commented on the challenges of measuring outcomes:

“Especially women going through TREM there is a big change in their concept of themselves, and these changes in terms of harming themselves, or risky sex behaviours, or drinking or drug use. It doesn’t mean they necessarily stop but it may mean they start using condoms, or stop exchanging needles, they started saying no instead of always saying yes. Things that are not necessarily statistically measurable....” (04USA Clinician, Substance Use)

Another discussed the importance of follow-up data with regard to re-victimisation:

“But we don’t incorporate that into the main analysis, and now as you are talking, no-body has ever looked at ongoing violence and how it impacts your treatment.” (03USA, psychologist, academia)

##### **4.4.4.2 Fidelity monitoring**

Stakeholders involved in two different trials involving Seeking Safety stated that in both occasions the fidelity assessment tool was simplified. In one trial, monitoring adherence to the fidelity of the intervention focused on rating the facilitators according to the quantity of components delivered but not its helpfulness. However, the intervention author pointed out the importance of rating both:

“So, all they did was rate the quantity stuff but not the process of it – you could spend the entire session talking about trauma and get a high rating on trauma, but they may have done it in terrible ways and so that is why that scale was developed to have both.” (08USA, Academia, Psychologist)

## **4.5 Discussion**

### **4.5.1 Philosophical approach driving service delivery**

The clear philosophical approach espoused by the practitioners working in England was driven by an understanding of how IPA impacts relations with the self and others, which are key treatment targets for PTSD (Herman, 2001; Kleim et al., 2013; van der Kolk, 2005). Non-pathologising, strengths-based practice centred on 'growth-fostering' relationships are core components of treatment long since promoted by advocates of gender responsive addiction treatment (Covington, 2000) and TIP (Harris & Fallot, 2001; Mills, 2015). This philosophical stance heavily influenced clinical practice, most notably in the quantity of safety and stabilisation work, focused on women's agency and choice, extending beyond typical time-limited PTSD treatments.

### **4.5.2 Extensive first stage safety and stabilisation work needed**

Pre-dominant in the narratives of practitioners in England was the propensity of time and effort required to support clients to establish physical safety, due to the complex interplay of substance use with PTSD symptoms and IPA, particularly when women faced with ongoing victimisation. Practitioners' descriptions of women's partners jeopardising treatment attendance and sobriety, echo findings in the literature (Galvani, 2009; Gutierrez & Van Puymbroeck, 2006). Women using substances are also at risk of repeated sexual violence by men in their drug-using circles or when involved in prostitution (Gilchrist et al., 2005; Teets, 1999). In order to respond to this, safe responses require emphasis on risk management, advocacy and multi-agency working (Itzin et al., 2010).

Self-medicating PTSD symptoms makes sense given that frequent responses to trauma often fall outside of a 'Window of Tolerance', a zone of emotional arousal that is optimal for wellbeing and daily functioning (Siegel, 1999). Common substances such as stimulants and depressants thus function to respond to states of too much (hyper) or too little (hypo) arousal but can also exacerbate these states (Back, Brady, Sonne, & Verduin, 2006; Kaplan, Hill, & Mann-Deibert, 2012). The concept of safety also extends to internal safety; supporting women to manage emotional regulation, substance use cravings, and other PTSD symptoms. Many of the

practitioners in England worked in services that offered interventions to address the mind-body connection, such as mindfulness and alternative therapies, as part of their standard service. Several of the US stakeholders also positively endorsed this response, and some with caution. As highlighted in the systematic review (Chapter 3), such interventions are now increasingly recognised as important first stage interventions in the treatment of PTSD (Van der Kolk, 2014). Practitioners also described how their services provided social activities, volunteering and other skills to support women in recovery, which is also highly complementary with the staged PTSD treatment model.

### **4.5.3 Developing TIP in England**

Whilst practitioners in England who were trained as psychologists, stressed the importance of their formal training to deliver trauma-specific treatments (and indeed TIP), this was not emphasised by their counterparts in the USA. This may reflect the fact that this work is relatively new in England, and appears to be primarily led by psychologists, which is not the case in the USA. Enlisting psychologists to support services in England may be an important first step for TIP gaining traction among substance use treatment and other services supporting women with complex needs (Against Violence and Abuse, 2017). Practitioners suggested that such investment is needed as a matter of priority in order to avoid tokenistic adoption of TIP, and unsafe delivery of trauma-specific services. There is now a strong body of international TIP practice guidance and fidelity checklists (Fallot & Harris, 2014; SAHMSA, 2014) to guide service development to ensure it is meaningful and safe. In the USA, there is a history of federal government initiatives to support providers in developing TIP and this has probably supported the diffusion of TIP across the USA among providers in the public health system (Capezza & Najavits, 2012). It is also noteworthy that substance use services in the USA offering integrated interventions such as Seeking Safety, were more likely to stipulate that they offered service provision for intimate partner violence, compared to those not offering integrated interventions (42% vs 23%) (Capezza & Najavits, 2012).

#### **4.5.4 Focusing on systems**

Both practitioners in England and the USA highlighted the importance of wrap around care and partnership working delivered alongside any integrated intervention, a point also stressed in the systematic review (Chapter 3). Practitioners in England emphatically illustrated the lack of service integration in the wider health and social care system, which in turn impacted their ability to effectively support women with co-occurring issues. Access to mental health services was particularly problematic, a serious issue highlighted by other practitioners working with rape victims in England (Brooker & Durmaz, 2015). The Full Frame Initiative, highlighted by one US stakeholder, may be the next level response. This 'systems-level' response moves beyond individual organisations, and privileges context and community in an attempt to provide social connectedness, safety, stability, mastery, and the meaningful access to resources for women facing multiple disadvantage (Smyth, Goodman, & Glenn, 2006).

#### **4.5.5 Considerations for the next phases of the PhD**

Practitioners from the USA with substantial experience in practice and research, using several well-known present-focused integrated models, provided valuable insights relating to the translation of such programmes into an English treatment setting. Strengths and weaknesses were highlighted for both Seeking Safety and TREM; both are frequently delivered in group-work and did not require practitioners to be clinically training in psychology, important considerations for compatibility with community-based substance use treatment. However, Seeking Safety was deemed more appropriate for women who are less advanced in the recovery from substance use. Suggested modifications focused on tailoring the materials to the specific socio-economic and literacy needs of the treatment population. Attention should be paid to the pacing of sessions, the accessibility of hand-outs for a diverse client group and the selection of appropriately skilled staff, which reflect the diverse client base being served. Consideration should also be paid to integrating more expressive activities and emotional regulation techniques into interventions that are heavily reliant on CBT. The service chosen to deliver the integrated intervention, should adopt the appropriate philosophical approach focused on relational and strengths-based practice, partnership working, and the development of organisational TIP. It is also important to capture intermediary outcomes and qualitative measurement of change, which prioritise women's voices;

as well as measuring ongoing victimisation from IPA, reiterating the recommendations from Chapter 3.

Based on this valuable learning from the stakeholder interviews, combined with the findings from the systematic review, Seeking Safety was chosen for the phase 4 feasibility study; and its review and adaptation are discussed in the next chapter.

## **Chapter 5: Intervention Review and Implementation**

This chapter comprises phase 3 of the PhD study and is broken into five sections. Section one draws on the learning from the previous phases to justify the choice of Seeking Safety for the next phase feasibility study, and to inform the choice of setting and study practitioners. Section two outlines the selection of the Seeking Safety topics, additional content and material adaptations. Section three details how the Theory of Behaviour Change was used to review the Seeking Safety content, plan the various delivery mechanisms, and consider wider service adaptations. Section four summarises the various training undertaken by me and the group facilitators and treatment services. Finally, section five provides a Logic Model summarising the different elements of the intervention, the underlying theories and influencing contexts and their relation to the expected short-, medium- and longer-term outcomes expected for the women participating in the intervention.

### **5.1 Choice of service setting, study practitioners, and integrated intervention**

#### **5.1.1 Choice of service setting**

Both the findings from the systematic review (Chapter 3) and interviews with practitioners from England (Chapter 4) highlighted the importance of multi-agency partnership working e.g., Independent Domestic Violence Advisors (IDVAs), as well the provision of ancillary services that meet the specific needs of individuals. Practitioners based in the voluntary sector highlighted the importance of providing a service that is highly relational, strengths-based, and flexible. These interviews provided an opportunity to explore potential services for collaboration in the feasibility study. The manager of the chosen study setting was interviewed as part of the previous phase and expressed an interest in collaborating. The chosen service, based in North London, also met a number of key criteria described above: although a mixed-gender service, a Women's Day Programme was offered and the service had a track record of good responses to intimate partner violence, as overseen and championed by the service manager. The service employed a Women's Complex Needs worker, who was also a qualified IDVA. The service also operated as



a 'community-base' offering breakfast and lunch every week day. Their recovery model is based on a stepped-model of care for substance use treatment:

- Stabilisation Programme (mandatory, 16 weeks): two-weeks residential detox followed by 14 weeks day programme of 3-4 days per week;
- Abstinence programme (mandatory, 28 weeks): first 12-weeks three days per week, followed by a more tailored programme for the remaining weeks;
- Women's Day Programme (optional, 10 weeks rolling): Women's Vulnerability Programme (2 hours), one-hour process group, and one-hour trauma-informed yoga;
- Wrap around support (optional): access to psychiatrist based at the detox clinic; one-to-one counselling; 12-step affiliated groups and Peer led SMART recovery groups; education and training courses; cookery classes, gardening art and music clubs; mindfulness group; holistic therapies (acupuncture, reflexology, massage, yoga); provision of drop-in surgeries from Solace Women's Aid, and a service providing welfare and debt advice;
- Volunteering: accredited peer mentoring programme, volunteering opportunities supported by a structured training programme;
- After-care (optional): provided for up to one-year post-completion of the structured programmes.

The new intervention replaced the Women's Vulnerability Group-work programme for the duration of the study and was open to women at any stage of recovery (i.e. on the Stabilisation, Abstinence, or After-care programme).

### **5.1.2 Evidence for TIP**

It was beyond the scope of the PhD to improve the wider organisational approach to TIP; however, the study treatment service was chosen in part for its willingness to work towards the foundations. Qualitative interviews conducted with the service manager and the facilitators, at the end of the study (see Chapter 6, section 6.7.3) sought to explore how TIP was being implemented in the wider service response. The service manager described how the service worked from the premise that all women entering the service had probably experienced some form of IPA in their lifetime.

She also offered up examples of how she believed the service met principles of TIP which are described below in more detail.

#### **5.1.2.1 Safe and welcoming environment**

The service manager provided examples of how staff worked to make the physical environment safe and welcoming. The quote below refers to the receptionist:

“...she is Nanny [receptionist name] you know, if nothing else she is the person who when they come through the door makes it feel warm, or says to people do you want a cup of tea, who are you here to see?”

She also described the importance of offering a hot meal and providing a place that people would want to return to after ‘graduating’ from the service:

“I always used to describe it as we are now your parents and when you finish your programme it’s like you are going off to university and we are your parents and you can just come home for holidays and Christmas, and they kind of got that and they liked that. They could just pop in whenever they wanted, yeah in terms of trauma informed, I think that is trauma informed.”

Challenges relating to a mixed-gender service involved ‘policing’ the predatory nature of some of the male clients. She described the steps they took to ensure that women are physically safe and to promote a culture where sexist and misogynist behaviour was not tolerated:

“Then of course the canteen area is quite informal and so the staff and the clients eat food together whatever, smoke cigarettes together you know, if there is prejudice remarks being heard, from men, or women, well usually it’s the men, then its picked up really quickly in key-work and it’s said, ‘look that can’t happen here.’”

#### **5.1.2.2 Addressing intimate partner violence**

The issue of intimate partner violence regularly featured as a standing item in the morning case management meetings. Discussions would frequently focus on potential risks to female clients from partners trying to access the service. Practice also included external advocacy with services to address safety concerns. The quote below concerns action taken to support one of the women who participated in the study:

“We got her moved from one flat to another flat, cause the local authority were unwilling to kick him out even though he is not on the tenancy and he is abusive...”

As well as employing an IDVA, the service offered a group-work programme aimed at men who were perpetrating abusive and unhealthy relationship behaviours towards their partner.

#### **5.1.2.3 Choice and Collaboration**

When asked about choice, the service manager stated that attendance was mandatory for the structured programmes (Stabilisation or Abstinence); however, there were many other additional services or activities that were all optional. Attendance on the Women’s Day Programme was always offered on the basis of choice as a deliberate strategy to keep the service accessible to women:

“The only thing that wasn’t mandatory was the Women’s Day, women could come and go because if we didn’t let them do that, we would have never had any women!”

When asked about service user involvement, the service manager explained they have always had two female service user representatives. She described her approach to collaboration:

“So, everything we have ever done is co-produced, I mean some stuff is already written, so my idea of co-produced is that even before the idea starts you have service users involved.”

Other examples of collaboration described were the provision of meaningful paid and volunteer roles within the service, positions in the kitchen, and co-facilitation of groups.

#### **5.1.3 Choice of study practitioners**

Two practitioners were chosen to facilitate the group-work intervention, informed by learning in the previous phases of the study relating to staff experience, competencies and skills. One facilitator, external to the study treatment service, was invited by me to take part due to her experience of therapeutic work with survivors of IPA; a competitive grant from Alcohol Research UK was received in order to fund her involvement. As a trained psychotherapist, she has been instrumental in developing a holistic trauma-informed clinical model (including present and past-

focused interventions), tailored to the specific cultural needs of women. The second facilitator was recommended by the service manager of the study treatment service. As the service's counselling supervisor, she had 15 years' experience working with women in substance use treatment using harm minimisation and abstinence-based models, with a focus on group-work using CBT. The use of two facilitators from different disciplines allowed for cross-fertilisation of skills and provided mutual peer support. Clinical supervision for facilitators was funded by the study treatment service and provided by a supervisor sourced by the external group facilitator.

### 5.1.3 Choice of integrated intervention

Learning from the systematic review (Chapter 3) indicated that present-focused interventions with extensive focus on first-stage safety and stabilisation work were most suitable for women with experiences of IPA, PTSD and substance use, particularly those with more severe symptoms. The findings also indicated that Seeking Safety and TREM had the largest evidence base, including process evaluation and guidance for implementation. The stakeholder consultation resulted in a summary table of strengths and weakness of these two models (Table 5).

Table 5: Strengths and weaknesses of TREM and Seeking Safety

TREM	
Strengths	Weaknesses
Starts touching on trauma recovery work at stage two once the group is bonded.	Long programme (33 sessions); topics must be completed in order.
Each section is structured in the same way - very transparent - women know what to expect	UK women's centre reported that after running three TREM groups -noticed the people dropping out were heavy substance users or those with high emotional regulation problems. TREM doesn't have enough affect regulation work.
Flexibility to incorporate more mindfulness or experiential exercises at the end of each session	Practitioners recommended that women with little sobriety wait a few months before taking TREM and take other groups like relapse prevention beforehand mindfulness.
Built by and for women. Includes more gender specific discussions such as ' <i>What it is to be a woman</i> '	When doing TREM women should also be taking relapse prevention or other substance use stabilisation programmes alongside.
	Specific TREM group training needed.
Practitioners in two different services in US running TREM had differing views as to suitability for women with recent IPA.	

Seeking Safety	
Strengths	Weaknesses
Focused on safe coping skills - less discussions around direct forms of IPA, and abuse stories, less triggering. Much more about the feelings and actions rather than the events of IPA.	12-Step treatment philosophy is ingrained into the intervention
Flexible in length of sessions, order and number of topics (can choose which of the 25 topics to deliver). Can start with the topics that are more skills coping before moving on to topics that may be more triggering. Easy for staff to lead the groups, very structured with clear guidance.	Homelessness service reported that the materials were too cognitively challenging for some women. Each session needed repetition of coping skills, what is safety etc. Required lots more time on psycho-education about trauma. Lots of defining and redefining terms.
Each week have to report in with safer coping - designed to get people to anchor the practice in their lives.	Dropped the commitment in check-out as they thought it may put people off coming back if they had not managed to stick to it
Provides space to address intimate partner safety within the session material. Originally designed for women. Sufficiently aligned to feminist principles, very empowering	Language of handouts need modifying e.g., assume a certain income level, tone of them is a bit preachy e.g. protect your body from HIV (many of the women already had HIV). Activities promoted assume a certain level of privilege
Session on PTSD would be a good place to introduce some of the newer learning about neuro-biology.	Language of handouts is too complicated, doesn't address issues of gender as well as TREM does
	Need to incorporate more grounding – mindfulness exercises, object-relational work (e.g. nurturing plants). Incorporate more emotional regulation work into the delivery.
	Each topic requires delivering over multiple sessions.

The content of this table was discussed with the two group facilitators and the service manager, who were also provided with the manuals from both interventions. The facilitators felt that the flexibility afforded by Seeking Safety to choose programme length and topic order gave it a distinct advantage over TREM in terms of adaptation to the local context. They were also guided by the stakeholder feedback that pointed to Seeking Safety being less triggering for women earlier on in their recovery. Despite its potential strength over TREM, some of the caveats noted include a lack of gender focus, the need to introduce more experiential and grounding exercises within each session, adaptation of language (i.e. converting American-English phrasing to English), and potential simplification of hand-outs to respond to the specific needs of the group both culturally

and pedagogically. The facilitators agreed that this could be addressed as part of the review and adaptation stage (see sec 5.2 below).

#### **5.1.4 About Seeking Safety**

The safe and structured format focuses on safety and coping skills and allows for the inclusion of women with wide variety of trauma experiences, full and partial PTSD symptoms, including those who are still facing ongoing victimisation. It also reflects the practicalities and realities of community substance use treatment services, which do not typically have psychologists available to deliver trauma-specific interventions, and who commonly deliver treatments via group-work.

Seeking Safety places emphasis on optimism, possibility of change, and the use of positive praise. Specific techniques involve teaching compassion rather than self-blame and reporting on good coping at each session. There is an explicit focus on strengths rather than pathology. The programme provides a broad list of over 80 coping skills in the first session which participants are invited to try within- and between-sessions relating to the weekly topic matter. As the intervention author states:

“The goal is that patients will never need to believe ‘there is nothing I can do’. If one tool doesn’t work, the idea is to use another” (Najavits, 2002, p.13).

Seeking Safety in its entirety consists of 25 topics. Guidance for implementation (Najavits, 2009, 2004, 2002) allows maximum flexibility for the number, type and delivery method of the topics, which reflect the needs of the service and participants. Topics can be delivered over several sessions. The Seeking Safety manual is supported by accessible training resources (online DVDs) and a comprehensive fidelity assessment tool (with online training available). More information about the review of the Seeking Safety intervention and selection of topics is provided in the next section.

## **5.2 Seeking Safety review and adaptations**

Once the service setting and study practitioners were decided, a small Steering Group of advisors were formed to oversee the review of Seeking Safety and discuss study implementation

considerations. This group comprised the service manager, the service user representative from the study treatment service, the two group facilitators, and drew on further expertise from women with lived experience of IPA 'experts-by-experience', outside of the Steering Group meetings. I facilitated the meetings, feeding back the views of the experts-by-experience, and telephone support was provided by the Seeking Safety intervention author Lisa Najavits.

### **5.2.1 Choice of group-work format**

Each of the group-work programmes delivered by the study treatment service at the time were delivered in blocks of 10-12-sessions (usually weekly). In keeping with this format, the Steering Group decided the format for Seeking Safety should comprise 12-sessions covering one new topic per session. The process of selecting the topics is outlined below. The Steering Group decided that the Seeking Safety group should operate as a closed group because of the nature of the topic content and to support group cohesion. Two separate groups would be facilitated in two rounds, delivered sequentially. In order to improve retention in the study it was decided to deliver the group over a six-week time period, with twice weekly sessions, as per the study design of the largest pragmatic trial of Seeking Safety conducted in the USA (Hien et al., 2009). This also allowed women enrolling with the study treatment service to join a new Seeking Safety group with minimal wait time. This was expected to facilitate the involvement of women with more severe substance use and PTSD symptoms, which is important given the evidence base for Seeking Safety identified in Chapter 3. The potential threat of service closure before the end of the feasibility study, due to the re-tendering of local treatment services happening at the time of the study, provided another pragmatic justification for the choice of a shorter and more intensive programme.

The Steering Group decided that each Seeking Safety session would also last 2 hours with a 15-minute break, mirroring the format of the other group-work programmes at the service. This time period allowed for the 5-minute check in per person for each group member (a core component of Seeking Safety) as well as sufficient time for the topic content. In addition to the 12-sessions, a pre-orientation session was planned in order to introduce the programme and allow the women to get to know the facilitators and each other (section 5.2.3). Given one of the research

parameters of the feasibility study was to explore the most optimal delivery format, flexibility regarding the delivery schedule for round two of the group-work was left open at this stage and subject to process evaluation feedback from the first round (see Chapter 7).

### 5.2.2 Seeking Safety topics

Seeking Safety topics are categorised into four content areas (Najavits, 2002). In addition to topics covering *Safety*, *Introduction to treatment*, *Termination*, and the *Life Review Game*, which span the categories, the other topics selected were:

(1) **Cognitive** topics (*PTSD*, *Compassion*, *Creating Meaning*, *Discovery*, *Recovery Thinking*, *When Substances Control You*, *Integrating the Split Self*) engage in standard cognitive therapy techniques are used to identify beliefs and undertake restructuring and reframing, replacing negative unhealthy cognitions driving behaviours, with healthier and more positive meaning.

(2) **Behavioural** topics (*Taking Good Care of Yourself*, *Self-Nurturing*, *Grounding*, *Red and Green Flags*, *Commitment*, *Coping with Triggers*, *Respecting your Time*) encourage participants to commit to actions, however small, related to the topic and which they are encouraged to carry out between sessions, and report on at the next session. For example, practicing a grounding skill and noting the effect it had on body, mind and substance use behaviour.

(3) **Interpersonal** topics (*Asking for Help*, *Setting Boundaries in relationships*, *Healthy Relationships*, *Getting Others to Support Your Recovery*, *Honesty*, *Community Resources*, *Healing from Anger*) emphasise the interpersonal to address the disruption to relational aspects of the self often resulting from childhood or adulthood abuse and encourages the development of supportive networks and rejection of destructive people.

4) **Case management** running throughout the programme delivery assumes that psychological interventions can only work if individuals have an effective and holistic coordinated care plan.



The process of reducing the 25 topics down to 12 took place in several stages, in discussion with Lisa Najavits, as detailed below.

### **5.2.3 Group consensus exercise**

The Steering Group and an additional female service user (with experiences of IPA and substance use) were involved in selecting the topics through a series of face-to-face meetings. An initial round of voting for topics individually was followed by a facilitated discussion of areas of disagreement and agreement, a conversation with Lisa Najavits, and followed by a final meeting with the Steering Group to select the final topics. Informed by Nominal Group Technique method<sup>36</sup> the process involved individuals rating the topics, coming together for discussion, then re-rating the topics together in order to reach final consensus.

All members were asked to individually read the Seeking Safety manual and choose the 12 topics they felt were most useful for the target group. For the service users their selection was guided by: 1) content they felt was important in order to address their experiences, and 2) topics that were not covered elsewhere in the other programmes offered by the study treatment services. The group facilitators were asked to consider their selection in terms of content they felt important to address based on their own disciplines. I selected sessions informed by the Behaviour Change Theory (described below in section 5.3), implementation guidance (Najavits, 2002), and process evaluations attached to previous trials of Seeking Safety (Brown et al., 2007; Hien et al., 2009).

#### **5.2.3.1 Topic selection – round 1**

At the meeting all the topics were listed on flipchart paper and participants individually indicated their favourite ones. The topics selected as ‘maybe’ were also noted. The results of this exercise are listed in Table 6 below. Topics in bold received the majority of ‘first choice’ votes, with the remainder receiving more than half the votes as ‘maybe.’ One topic, marked with a star, received no votes.

---

<sup>36</sup> See <https://www.cdc.gov/healthyyouth/evaluation/pdf/brief7.pdf>

Table 6: Topic selection based on first round votes in consensus exercise

Round one		
3+ votes	2 votes	≤1 vote
Safety	When substances control you	Case management/Introduction to Treatment*
PTSD	Taking good care of yourself	Community resources
Grounding	Recovery Thinking	Respecting your time
Asking for help	Integrating the Split Self	Life Choices Game
Compassion	Coping with Triggers	Getting others to support your recovery
Red and Green Flags	Commitment	
Honesty		
Creating Meaning		
Setting Boundaries in Relationships		
Healthy Relationships		
Discovery		
Self-Nurturing		
Healing from Anger		
Termination		

I then facilitated a discussion with the group to explore areas of agreement and disagreement with a view of moving towards consensus on the final topics selected. There were no clearly defined differences in opinion between service users, facilitators and me. However, there were individual disagreements on particular topics.

#### 5.2.3.1.1 Areas of disagreement

*Integrating the split self:* one service user rejected this topic because she felt that the language was ‘off putting’ and couldn’t understand the content, whilst another service user had this as a ‘maybe’ because she felt it is not covered elsewhere on other programmes at the service. I initially selected this topic in my top 12 because it touched on a specific issue related to Complex PTSD (dissociation). However, none of the facilitators chose it. Discussion about this topic highlighted how the subject matter may be highly triggering for some women (also noted by the programme author, Najavits, 2002 p.226). The facilitators also said the topic delves into a specialist

therapeutic area, that may be difficult to contain in one session, and possibly difficult for a counsellor to follow through in one-to-one sessions without specialist training. It was agreed that these arguments warranted rejecting this topic in favour of others.

*Commitment:* No-one in the group had prioritised this topic because it features as a core component as the out-of-session activity that women choose at the end of each session. One facilitator felt strongly that the language of '*breaking promises and commitments to others*' was too harsh and judgemental for a group of women who battle with guilt and shame due to their trauma and substance use. She felt that this approach does not sit well with her therapeutic approach.

*Life Choices Game:* One service user felt this topic would be fun, balancing the heavier topics. She argued that it would also help women who missed any of the topics. The group discussed the possibility of merging this with the *Termination* topic.

#### 5.2.3.1.2 Areas of agreement

*Case Management and Community Resources* were identified as being available as part of the study treatment service care plan. *Introduction to Treatment* would be included in the pre-orientation session. *Getting Others to Support Your Recovery* involves inviting a supportive person to attend the session which all felt may be difficult and isolate those who were unable to bring someone. *Safety, PTSD, Grounding, Healing from Anger, Self-Nurturing* and *Creating Meaning* were all seen as priority topics.

#### 5.2.3.1.3 Other discussion points

Several members of the group highlighted the similar nature of some of the topics, which made deciding between them difficult. This included *Setting Boundaries in Relationships vs Healthy Relationships*; and *Taking Good Care of Yourself vs Self-Nurturing*. Both facilitators suggested exploring the possibility of merging some of these topics.

*Creating Meaning, Recovery Thinking and Discovery* are all topics whose foundations lie in cognitive therapy and all deemed important for addressing negative cognitions. However, it was agreed one or two of these would be sufficient in order to allow a balance of other topics.

The topics of *Coping with Triggers* and *When Substances Control You* included content covered elsewhere in the other group-work programmes, but with the caveat that they would not be discussed in the context of PTSD. A suggestion was made to merge some of the content into the PTSD topic. Finally, in an attempt to make space for as many topics as possible, the study practitioners suggested introducing Safety as part of the pre-orientation session (sec 5.2.3).

#### **5.2.3.2 Consultation with Seeking Safety intervention author**

A Skype conversation took place with myself and Lisa Najavits on 20.02.17 to discuss the selection of topics by the stakeholders. Firstly, Lisa stressed the importance of keeping the topic content as written and that the volume of material meant that combining topics is unsuitable. She also discouraged shortening the *Safety* topic. She said *Safety* is one of the most important topics and needs a full session. She advised that either of the relationship topics would be suitable and to go with personal preference. She also advised that *Taking Good Care of Yourself* may be better than *Self-Nurturing*. She stated that the *Honesty* topic was popular and recommended that it is prioritised over other topics. Finally, she recommended using the content of the *Case Management/Introduction to Treatment* topic as a good framework for the pre-orientation session.

#### **5.2.3.3 Mapping Seeking Safety Topics against relevant Behaviour Change Techniques (BCTs)**

Following this discussion, I then mapped the selected Seeking Safety topics against the BCTs discussed in sec 5.3 below. This process identified the value of topics categorised as 'behavioural' and 'interpersonal' because they contained exercises relating to the BCT *Behavioural Practice and Rehearsal*. This highlighted the need to ensure sufficient topics of these categories. The topics of *Recovery Thinking* and *Discovery* fall into the Seeking Safety cognitive topics, and either of them were deemed useful for contributing towards promoting the BCT *Framing/reframing Self-Talk* and *Valued Self-Identity*.

#### 5.2.3.4 Topic selection – round 2

The feedback from Lisa Najavits and the information from the BCT mapping was shared with the Steering Group. Because topic content could not be merged, following discussion, the group decided on the topic *Setting Boundaries in Relationships* rather than *Healthy Relationships*; this was because the former provides more comprehensive treatment of issues relating to trust, closeness and distance, as well as covering awareness of intimate partner violence. In contrast to the advice of Lisa Najavits, the group decided on *Self-Nurturing* (rather than *Taking Good Care of Yourself*) because it provided slightly more focus on education and the promotion of self-soothing and self-care techniques which focus on the mind-body connection. All the group felt this element of the programme required priority. *Coping with Triggers* was rejected in favour of the last 2 undecided topics: *Asking For Help* and *Recovery Thinking*. The group struggled to decide between the two and the decision was left open for the study practitioners to decide once the groups were formed, in accordance with identified needs. In practice *Recovery Thinking* was used in both Group 1 and Group 2.

Finally, the study practitioners suggested a topic order (Table 7) which balanced the heavier and less intense topics. This was left open to change in order to respond to the needs of the participants, should the practitioners so wish.

Table 7: Final selection of topics and their content category

Name of session	Content category
Pre-orientation session	Introduction to treatment
1) Safety	Combination
2) PTSD: Taking Back Your Power	Cognitive
3) Detaching from Emotional Pain (Grounding)	Behavioural
4) Red and Green Flags	Behavioural
5) Self Nurturing	Behavioural
6) Healing from Anger	Interpersonal
7) Compassion	Cognitive
8) Recovery Thinking	Interpersonal or Cognitive
9) Setting Boundaries in Relationships	Interpersonal
10) Creating Meaning	Cognitive
11) Honesty	Interpersonal
12) Life Choices Game	Combination

#### 5.2.4 Seeking Safety material review

The Steering Group were also involved in a review of the material and hand-outs from each individual topic. We were joined by two further women experts-by-experience, and who were identified through another voluntary sector organisation. I met with these two women in separate meetings and fed their views back to the Steering Group. The material review process involved: 1) a review of the hand-outs from the proposed 12 topics to consider language and terminology, cultural references and messages relating to gender; 2) exploration of content material related to intimate partner violence; and 3) consideration of providing additional material/content to promote alternative mind-body/self-soothing activities.

##### 5.2.4.1 Review of handouts

A number of language changes were suggested in order to make the hand-outs more localised to the culture and treatment environment in England. Some of the suggested changes were felt

to be quite fundamental in order to coalesce with the treatment philosophy in the UK and enable clients to most optimally engage with the material. For example, changing references of '12-step' to 'peer support', 'physical self-abuse' to 'self-harm', and 'working as a prostitute' to 'involvement in sex-trading'. Others were felt to be useful changes, but optional. The proposed changes, outlined in Appendix 13, were not related to overall content or mode of delivery and were therefore perceived as compatible with the fidelity of the intervention. In addition to the language changes, the review group also recommended that the general layout, font and font size be changed, and the inclusion of images and page borders where possible.

#### **5.2.4.2 Final decisions regarding changes to the hand-outs**

Despite the need for the identified language changes, Lisa Najavits advised against it for several reasons. Her main concern was that the people proposing the changes had not delivered or participated a group. In her experience, group participants in other countries had not identified problems with the language. She advised to use the hand-outs as they were, making verbal modifications to the language as needed, and to collect feedback from the participants as part of the process evaluation. The Steering Group decided it was important to follow her advice. As such all-original hand-outs were used as per the manual, with noted changes provided to the facilitators to refer to verbally in the sessions. Participants were asked about their views of the hand-outs as part of the evaluation.

#### **5.2.4.3 Review of the content focused on intimate partner violence**

The Steering Group discussed changes to the content of the material relating to one specific form of IPA, intimate partner violence, within the *Setting Boundaries in Relationships* topic. This included consideration of new material to help participants identify unhealthy intimate partner relationships e.g. using the Power and Control Wheel (Domestic Abuse Intervention Programme, 1984). However, the group concluded that such discussions may run contrary to a key tenant of Seeking Safety regarding the limitation of trauma discussions. Instead the following provisions were made:

- To use the handout containing a brief checklist of behaviours common to domestic violence was used. This was followed by a discussion of support services available in the study treatment service (e.g., IDVA) and by partner services;

- Unsafe relationship behaviour from others would be revisited in each session using the check-in exercise question relating to 'unsafe behaviours';
- Group facilitators would ensure follow-up of any issues raised by the participants as part of the case management.

#### **5.2.4.4. New components**

The BCT analysis, discussed in sec 5.3 below, identified that the provision of aide-memoires (BCT Prompts/Cues) could help participants utilise the grounding techniques delivered as part of the topic *Grounding*. The study practitioners also identified the need to include more activities to target the mind-body connection. Therefore, as part of the pre-orientation, women were also invited to make up a 'comfort kit' from a selection of materials provided, which involved the five senses; this included essential oils on cotton wool pad, sweets, feathers, a bell. At the end of each session, the practitioners would also engage in a ritual, which involved spraying the hands of each participant with a choice of fragrant smells. As another adaptation, the facilitators would demonstrate a new mindfulness/grounding technique before the group check-in to help centre people in the room and to provide opportunity to try new techniques in each session (*BCT Demonstration of the behaviour*). Women only trauma-informed yoga, delivered by an experienced yoga teacher, was offered as an optional extra after the Seeking Safety group session on Mondays.

#### **5.2.3 Pre-orientation session**

The pre-orientation session was conceived as an opportunity for participants to discuss their expectations for the group, meet the facilitators and their peers, and learn more about the Seeking Safety content, format and structure, drawing on guidance from the Seeking Safety manual regarding '*Introduction to Treatment*' and '*Case Management*' (Najavits, 2002). Three hand-outs, adapted from manual, were disseminated and discussed with the participants, covering: 1) Seeking Safety content (e.g., topics, format for check-in, quotes, discussion, 'commitments', and check-out); 2) Practical Information about the group (e.g., logistics, sources of external support out-side of sessions); and 3) How to get the most out of the group (e.g., active participation, notice your strengths). An adapted version of the 'Group Agreement' from the manual was also



disseminated, and women were asked for their views and invited to make changes or additions. The session also provided an opportunity for women to discuss any concerns they may have about participation. The second part of the session comprised the experimental exercise involving the construction of individual 'comfort-kits', as described above, and women were provided with folders to store their materials.

The next section in this chapter explains how Behaviour Change Theory was used to review, refine and adapt the Seeking Safety intervention and inform decisions discussed above in the previous section.

### **5.3 Using Behaviour Change Theory to guide the Seeking Safety review**

The Behaviour Change Wheel (BCW) (Michie et al., 2011) is a structured framework for illustrating the behaviour change theory underpinning Seeking Safety and implementation decisions for the next phase feasibility study. Given the study involves the delivery of a pre-existing intervention, and the limited scope for changing the core content of the intervention (Najavits, 2009), this framework was used principally to help inform: 1) the selection of Seeking Safety sessions (reduced from 25 to 12); 2) the additional considerations not catered for in the standard Seeking Safety content; and 3) the wider service delivery aspects required to support the identified behaviour change.

The BCW is a tool based on the synthesis of 19 theoretical frameworks of behaviour change found in the research literature. It provides a framework for applying theory and evidence to designing a behaviour change intervention and draws on a detailed list of taxonomy of 'behaviour change techniques' (BCTs) developed by expert consensus (Michie et al., 2014). Whilst the BCW has been criticized for oversimplifying complex social realities by paying insufficient attention to theorizing mechanisms and how they vary by contexts (Fletcher, 2016), the framework does stress the importance of considering the internal and external conditions necessary for individuals to acquire the behaviour change of interest. This study has used findings from the systematic review (Chapter 3) and from qualitative interviews with stakeholders (Chapter 4) to fully consider

the wider range of internal and external conditions important for effective intervention implementation. These findings inform the BCW framework and involve three main steps in the refinement of the Seeking Safety intervention, outlined below.

### **5.3.1 Identifying the target behaviours for change**

The first step involves identifying the key behaviours that require change in order to address the identified problem, acknowledging that these exist in a wider system of other interacting behaviours, by the same individual or others. As outlined in Figure 10, the individual behaviours to target as part of Seeking Safety were:

- 1) replacement of substance use and PTSD related behaviours with safer coping strategies; and
- 2) adoption of physical safety measures to prevent current and future victimisation.

Other behaviours in the wider system influencing these behaviours were:

- 3) treatment services identifying and facilitating access to external risk management processes;
- 4) providing a safe treatment environment; and
- 5) accessibility of safe social support network and activities.

Informed by the learning in previous phases, I proposed that that the target behaviours interact in the following ways: a physically safe treatment environment avoids re-traumatisation of individuals and re-triggering PTSD symptoms; the detrimental effect of unsafe relationships impacts on the ability to implement safe coping strategies; the establishment of safe social support is important in order to practice and reinforce coping strategies and build self-esteem, thus improving the notion of self-efficacy which enhances the ability to pursue goals. Increased coping skills facilitate reduced substance use and access to second stage treatment, requiring memory processing, if required.

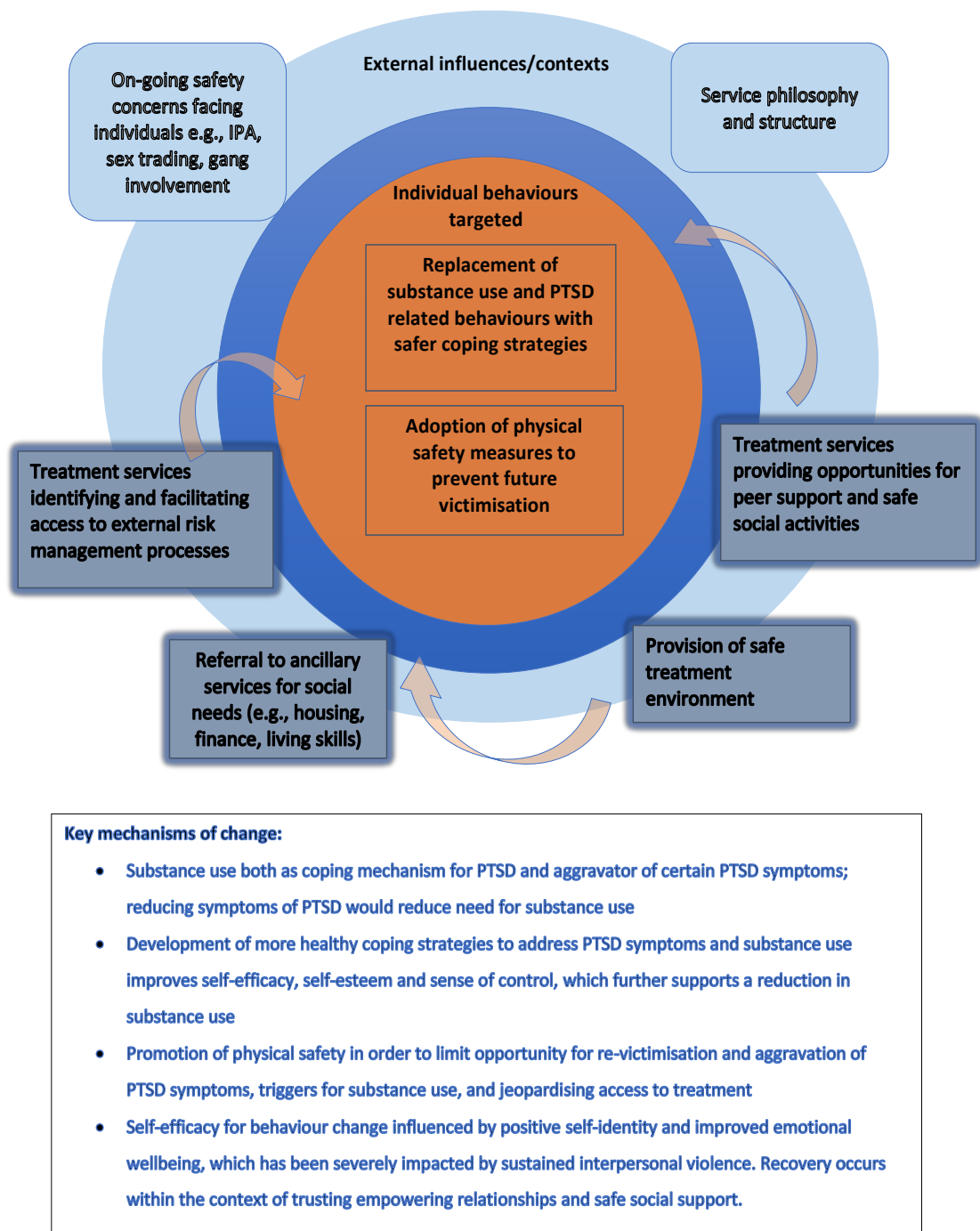


Figure 10: Behaviour change targets and the wider external influences/contexts

### 5.3.2 Changes required to promote the targeted behaviours

The next step involves the analysis of behaviour change according to the COM-B model which theorises that changing incidence of any behaviour involves changing one or more of the

following: *capability*, *opportunities* and *motivation* relating to the behaviour itself or behaviours that compete against or support it (Michie et al., 2014). As outlined in Figure 11 below, these domains do not operate in isolation but impact and interact with each other and the behaviour.

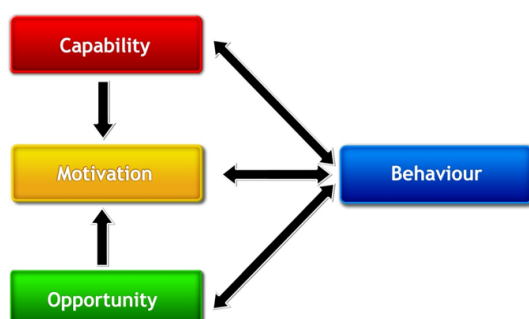


Figure 11: COM-B model  
(Michie et al., 2014)

Each COM-B component is split into further domains: Capability (psychological/physical), Opportunity (Social/physical) and Motivation (automatic/reflective). The Theoretical Domains Framework (TDF) expands the COM-B components further to include a total of 14 domains. Using these domains, one is guided to assess in a structured and systematic way, ‘what needs to change?’ in order to facilitate the required behaviour change. Not all domains may be relevant or require any change in behaviour and can therefore be omitted. Appendix 14 provides a detailed overview of the conditions and changes (at both the individual and organisational level) identified to facilitate the target behaviours outlined previously in Figure 10.

Many of the domains interact with each other. Increasing a person’s *capability* to employ coping strategies for PTSD symptoms and experience that they are effective then leads to increased *reflective motivation* to use the strategy to reduce substance use, because the person believes there are alternative strategies to managing distress other than via using substances. The *capability* to use such strategies also impacts on *automatic motivation* because PTSD symptoms can be brought under control, rather than being processes that ‘happen’ to an individual and overwhelm them.

### 5.3.3 Identifying intervention functions and BCTs

The next step in the BCW analysis involves the consideration of nine core intervention functions that can be used to promote the target behaviours and address the barriers to their use. There are a range of BCTs taken from the BCT Taxonomy (Michie et al., 2014) to deliver the function. The defining characteristic of a BCT is that it is an “*observable, replicable, and irreducible component of an intervention and a postulated active ingredient*” (p. 145). Note that many BCTs can serve more than one function and not all functions will be applicable to every intervention.

The functions identified as being most applicable to Seeking Safety were: *Education* (increasing knowledge or understanding); *Persuasion* (using communications to induce positive or negative feelings or stimulate action); *Training* (imparting and Practicing Skills); *Environmental Restructuring* (change the physical or social context); *Modelling* (provide an example for people to aspire to or imitate); and *Enablement* (increase means/reduce barriers to increase capability).

Appendix 15 outlines 32 BCTs identified as facilitating the targeted behaviour change, accompanied with descriptions of how the Seeking Safety core content and topic content would promote the BCT in question. This is mapped against the COM-B and TDF Domains identified in Appendix 14 and mostly related to the COM-B domains of *capabilities* and *motivation*. As discussed in the previous section, the mapping of these BCTs against the Seeking Safety intervention helped inform the selection of topics and identify the additional content needed. The COM-B domains of *opportunity* identified a number of organisational factors which need to be considered to support the delivery of the Seeking Safety intervention. These relate to the following BCTs: *Social support (emotional and practical)*, *Remove aversive stimuli*, *Restructuring the physical environment*, *Avoidance–reducing exposure to cues for the behaviour*, *Adding objects to the environment*. and *Framing/Reframing*.

## **5.4 Training**

### **5.4.1 Seeking Safety fidelity monitoring training**

I undertook an adapted version of the intervention fidelity training provided to researchers who wish to use Seeking Safety. This was offered at no cost by Lisa Najavits and involved watching four video-taped sessions in a sequential order (three group-work and one individual session) and completing the Seeking Safety Adherence Scale score-sheet (Appendix 16). The score sheet comprised 21 sections each rated with a score of 0-3 in the areas of adherence and helpfulness. This was then returned to Lisa who provided the written 'gold standard' answers before providing access to the next video. This training was adapted from the standard training and excluded the additional supervision sessions normally provided. Hence it was a condition of this training, that official certification would not be provided.

### **5.4.2 Group facilitators training**

Lisa Najavits offers a range of training options to support the delivery of Seeking Safety within services and in research studies. Due to budget constraints, I developed a one-day training using four Seeking Safety training DVDs, drawing on my professional experience as a trainer. I then delivered this training to both group-facilitators in August 2017. Appendix 17 outlines the content of the training.

### **5.4.3 Training for all staff in the study treatment service**

In order to inform the wider staff team of the study treatment service about the Seeking Safety intervention, and provide more information about TIP, another one-day training was delivered to the entire service staff in September 2017. It was led by the external group facilitator, an experienced trainer in IPA and PTSD. The agenda covered: an introduction to trauma, the impact of trauma on the brain and mental health impacts, clinical conceptions of PTSD and Complex PTSD, the staged model of PTSD treatment, gender responsive treatment, grounding and self-soothing exercises, and a session on organisational TIP and Seeking Safety (delivered by myself).

## 5.5 Logic model for the intervention

Finally, a Logic Model (Figure 12) was drawn up which summarises graphically the underpinning assumptions and theories outlined in this chapter combined with the implementation decisions taken. The theories of change underpinning the intervention justify the expected short-, medium- and longer-term outcomes in a linear fashion. However, in reality an individual's journey to recovery is highly idiosyncratic and many loop back mechanisms exist between the outcomes. They will be initiated over different time periods and will depend on many of the contextual factors listed. The first stage outcome relating to motivations (e.g., beliefs in capabilities, or beliefs that the coping strategies work) will increase over the longer term if an individual experiences successful symptom management as a result. Improved social support, expected over the medium-to-longer-term will also have a direct impact on feelings of self-esteem and may facilitate reduced motivation to use substances.

As discussed earlier, the intervention is based on the theory that women are using substances to self-medicate symptoms of PTSD and therefore a reduction of PTSD symptoms would be expected to precede substance use. However, a reduction in certain substances known to exacerbate PTSD may also contribute to reduced PTSD symptoms, creating a circular relationship. Moreover, whilst some women are expected to improve without access to second stage PTSD treatment involving memory processing, others may require this component of the staged treatment model in order to fully recover. Reduction and stabilisation of substance use for a sustained period may facilitate a referral to this treatment provided by the local Mental Health Trust.

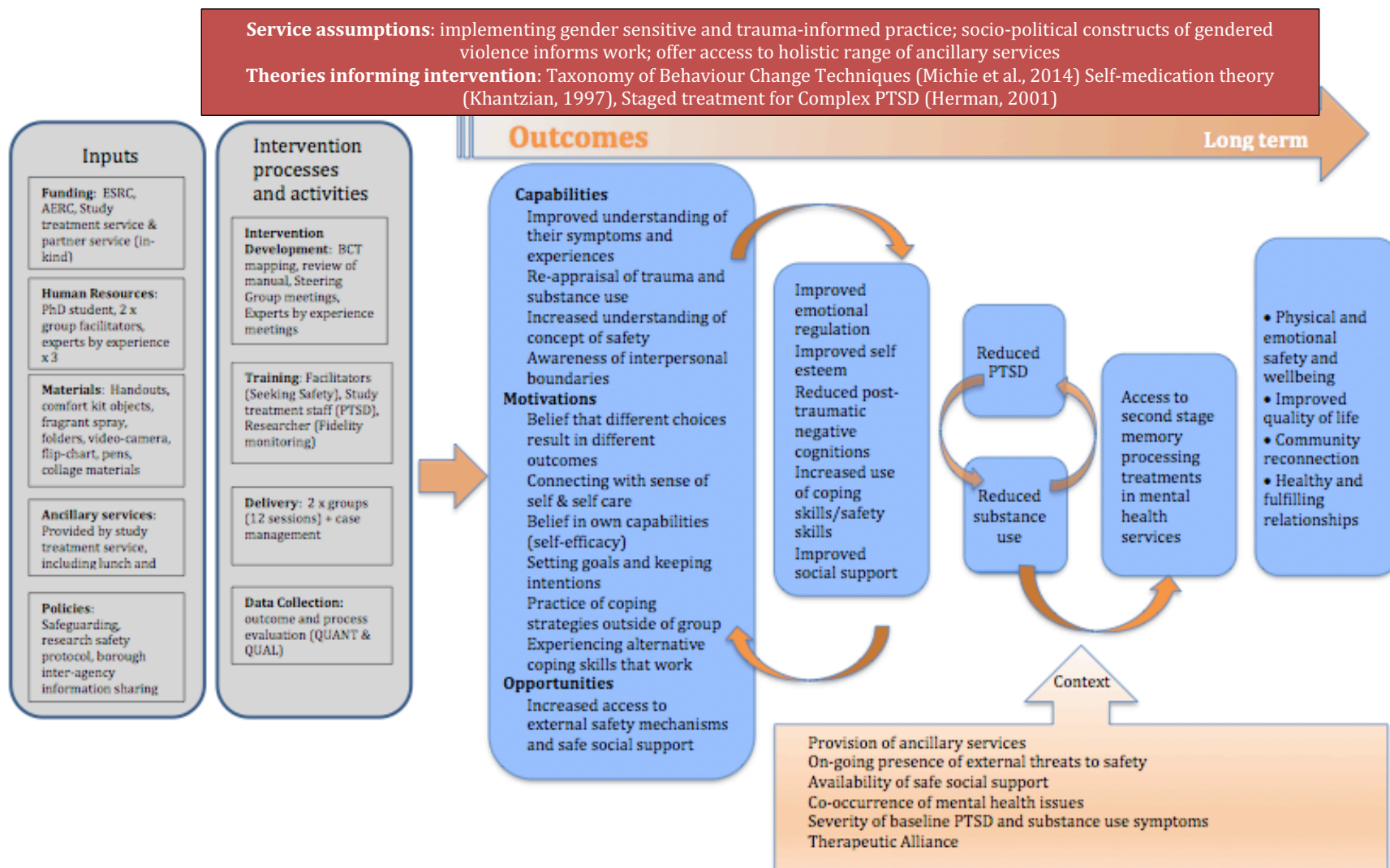


Figure 12: Logic Model for delivery of the Seeking Safety intervention



## Chapter 6: Feasibility Study Methodology

The previous chapter outlined the selection process for the study setting and group facilitators and illustrated the review process used to refine and adapt Seeking Safety for the purpose of this study. The fourth and final phase of the PhD study involves assessing the acceptability and feasibility of delivering and evaluating this adapted version of the Seeking Safety intervention in a group-work format within a substance use treatment service in England. This phase is aligned to the 'feasibility/pilot' stage of the MRC framework for the evaluation of complex evaluations and involves a concurrent mixed-methods design (see Chapter 2) with the following key objectives:

- 1) To assess the ability to recruit the target population and retain participants in the group and explore how this can be enhanced;
- 2) To evaluate the suitability of eligibility criteria, recruitment and refusal rates and follow-up rates immediately post-intervention and at 3-months post-intervention;
- 3) To explore the implementation of fidelity monitoring and assess the required training and supervision needed to support facilitators to deliver the intervention with required fidelity;
- 4) To qualitatively explore the suitability and acceptability of a variety of study measures relating to women's experience of violence and safety, substance use, and mental health and measure completion rates and missing data;
- 6) To identify wider contextual factors and the nature and quantity of wrap-around services provided to women participating in the intervention that may enhance or detract from effective delivery and positive treatment outcomes;
- 7) To explore the acceptability, perceived value, helpfulness, harms and unintended consequences of the intervention amongst women attending and professionals delivering the

intervention, using focus groups and semi-structured interviews, and quantitative data as appropriate;

8) To undertake exploratory analysis of within-group change in substance use, PTSD symptoms, depression, self-esteem, trauma cognitions, emotional regulation, and coping skills immediately at end of the intervention and 3-months post-intervention, assessing for direction of travel, variances and 95% confidence intervals;

9) To undertake exploratory analysis of data collected by the PTSD measure (PCL-5), to explore the numbers of women experiencing clinically meaningful change as measured by a minimum threshold of 10-point change in the PCL-5 (Weathers et al., 2013).

## **6.1 Setting and Intervention**

A detailed description of the format of the Seeking Safety intervention along with the choice of substance use treatment setting is described in Chapter 5. To summarise, 12-sessions were delivered over 6 weeks (twice weekly) with a pre-orientation session held the week before. Each session lasted 2 hours with a 15-minute break and was co-facilitated by two experienced practitioners; one a qualified counsellor with substantial experience working with women in substance use treatment and the other a psychotherapist specialised in trauma therapy. Two groups were delivered in succession. The first group ran from Oct-Dec 2017 and the second group ran from January-March 2018.

### **6.1.1 Minimal session dose**

This study followed the precedent of the Women and Trauma study design which employed 12-sessions of group-work over six weeks and deemed attendance at any six sessions (50%) as minimal dose exposure (Hien et al., 2009), excluding pre-orientation.

## **6.2 Participant eligibility criteria**

### **6.2.1 Inclusion criteria**

To be eligible for the study, participants were required to meet the following criteria:

- i) 18+ years old and identify as female;
- ii) currently receiving treatment from the participating substance use treatment services or willing to enrol in their Women's Day programme and assessed as suitable by staff;
- iii) assessed as meeting criteria for full- or sub-threshold PTSD according to DSM-V criteria\* as measured by the self-report PTSD Civilian checklist for DSM-V (PCL-5) (Weathers et al., 2013);
- iv) accessing a domestic or sexual violence service historically/currently, **or** reporting Criterion A IPA trauma for DSM-V, **or** replying positively to anyone one of the nine IPA items on the WCDVS Life Stressor Checklist- Revised (McHugo et al., 2005), **or** an additional question relating to safety in an intimate relationship;
- v) have sufficient English to complete questionnaires and engage in CBT.

\* This study used the definition of sub-threshold PTSD for DSM-V as recommended by Brançu and colleagues; one symptom within each cluster (as well as duration and impairment requirements) (Brançu et al., 2016).

### **6.2.2 Exclusion criteria**

Women were excluded from the study if they:

- i) were not enrolled at the participating substance use treatment service or did not wish to attend the Women's Day programme;

(ii) were considered by service staff to be too unwell or distressed to participate in the study e.g., a suicide attempt in recent months or hospitalisation;

(iii) were unable to give informed consent to participate in the study;

(iv) were currently receiving other psychological interventions for PTSD;

(v) did not consent to having group-work sessions video-taped or sessions observed in-situ.

### **6.3 Identification and recruitment of study population**

Participants were identified and approached through several channels:

i) Key-workers at the participating service and partner services approached female clients who they thought may be eligible, informed them about the study and provided the participant information sheet. If interested the potential participant was provided with my contact details to allow them to make contact of their own accord;

ii) Posters, with my contact details, advertising the research study were placed in waiting rooms and toilets at the treatment service, and one of the partner substance use treatment services. The posters provided my contact details so that potential participants could make direct contact;

iii) Staff at the study treatment service organised two recruitment sessions where I presented details of the study and the intervention, provided copies of participant information sheets and collected details of any interested women for me to telephone with their consent;

iv) The recruitment process also involved the active participation of the service's female service user representative (from the initial Steering Group, Chapter 5) who spoke individually to women in the service and attended a borough-wide service user meeting to introduce the study to other service user representatives.

### **6.3.1 Service user involvement**

The service users involved in the initial review of the intervention material (see Chapter 5) also provided input into the recruitment and study protocol. They reviewed the participant information sheet, consent form, and study advertisement (Appendices 18-20), to advise on language accessibility. Changes made to the participant information sheet and advertisement as a result of this input were:

- reiterating the limited trauma discussion allowed by the intervention;
- emphasising how taking part in the study could help other women;
- changes to wording to make it more accessible: 'interpersonal abuse' and 'trauma' changed to 'violence or abuse'; 'ascertain' changed to 'ask.'

Furthermore, several service users raised the issues of the wrap-around care that would be made available to the participants attending the group, stressing that one-to-one support should be made available. Service users were reimbursed for their time, with a £15 shopping voucher given for each meeting attended.

## **6.4 Screening assessment**

An initial screening assessment with interested women took place face-to-face in a private room at the study treatment service. Efforts were made to schedule these on Mondays to co-inside with a programme of activities for women, including trauma-informed yoga. Alternatively, women were offered the option of attending a partner service with support staff available. This assessment was self-administered in three parts and designed to take between 5-10 minutes. Firstly, women were asked to self-complete the PCL-5 questionnaire including the Criterion A checklist for type of trauma experienced. Upon returning this questionnaire, if any of the trauma types checked were IPA, no further questions [detailed in sec 6.4 (iv) above] were asked about IPA. Secondly, participants were asked to self-complete a questionnaire comprising socio-demographics. Lastly, I asked questions regarding housing status, social services involvement, substance use treatment and mental health, including questions regarding recent suicide attempts or hospitalisation. If a woman answered positively to these questions, or appeared to struggle with English language, I discussed their eligibility with the Seeking Safety group facilitator at the study treatment service.

If women met the eligibility criteria, I summarised the participant information sheet, reiterated their right to withdraw from the study, and answered any questions they had. Women were asked to sign two copies of the consent form (Appendix 19) and one copy given to them for their records. Women were then asked to provide their full contact details, including a safe contact, and enquiries made about safety for making contact. A support services card was offered (and checks made that it was safe to take home). Finally, I enquired about any feelings of distress and if women would like to speak to service staff. Arrangements were made to follow-up with them to arrange the baseline interview two weeks before the start of the group.

Service users who did not meet eligibility criteria at the screening stage or did not choose to participate after the screening interview were asked for consent to keep the screening data and socio-demographic details.

## **6.5 Sample Size**

The aim of this feasibility study was not to estimate parameters for the sample size calculation for a future trial, nor test for hypotheses relating to outcome changes. Given the focus was on intervention acceptability, in terms of testing implementation and training staff, a purposive sampling method was employed (Eldridge et al., 2016). The sample size was therefore informed through discussions with methodological experts, with a focus on qualitative methodological concerns and practical factors (S. Eldridge, personal communication, 31 August 2017; O’Cathain et al., 2015). The study aimed to recruit a maximum of 24 women across the two rounds of group-work. This target was guided by the following considerations:

- The study treatment service estimated that between 35-40 women would be enrolled in the service during the period of the study, limiting the options for two control groups to be created alongside the two treatment groups;
- Implementation guidance for Seeking Safety and evaluation studies do not give a recommendation for group size (Najavits; 2009). However, the two group-work facilitators expressed concern about large group sizes in terms of managing the diversity of participant needs. They requested that no more than 12 women were recruited to start the first round of the group. It was envisioned that smaller group sizes would help manage

check-in (5 mins per person), check-out, and allow sufficient time for topic discussion and case management<sup>37</sup>. Optimal group size was explored qualitatively in interviews with the participants and facilitators as part of the process evaluation;

- Attrition was estimated to be approximately 30% over the course of the study, in keeping with other studies with similar treatment populations (Fowler & Faulkner, 2011) resulting in an expected final total sample size of 16-17.

## 6.6 Study measures

The choice of ‘constructs’ to measure in the study, beyond that of PTSD and substance use, were informed by results of phase 1 & 2 of the study as illustrated in Table 8. In addition, measures for depression and trauma cognitions were justified due to the strong associations with PTSD (Nishith et al., 2005; O’Campo et al., 2006; Resick et al., 2002) and association with substance use (Davis, Uezato, Newell, & Frazier, 2008; Hobden et al., 2018) and evidence for their role as mediators of PTSD treatment outcomes (Cloitre et al, 2004; Kleim et al., 2012). The measures were collected through a structured interview at baseline (T1); immediately post-intervention (6-8 weeks post baseline) (T2); and at 3-months post-intervention (T3) and are summarised in Table 9, along with their psychometric properties and the administration time-points.

---

<sup>37</sup> These are components of the Seeking Safety format, see Chapter 5

Table 8: Constructs measured in the feasibility study informed by previous phases of the PhD study

	Literature review (Phase 1)	Consultation Stakeholders (Phase 2)
Measure repeated IPA at each time-point	✓	
Intermediary variables: <ul style="list-style-type: none"> <li>• Self-esteem</li> <li>• Emotional regulation</li> <li>• Trauma cognitions</li> </ul>	✓ ✓□	✓
Depression		
Active ingredient of intervention: coping skills	✓	✓
Quality of relationships: alliance with group facilitators and other group members	✓	✓
Potential moderators of treatment outcomes: <ul style="list-style-type: none"> <li>• Social support</li> <li>• IPA</li> <li>• Wrap-around services</li> </ul>	✓□ ✓□ ✓	✓
Importance of qualitative measurement		✓

Other considerations informing the final choice of measures included:

- participant burden; in an effort to keep the interview under one-hour, brief measures or short versions were chosen;
- validation in similar treatment populations;
- free to obtain and use in the study and limited training required for administration; and
- recommendations in literature reviews of relevant measures.

Appendix 21 provides more information about the content of the different measures, the reason for their choice, and scoring of variables.



Table 9: Summary of measures and administration time-points in the feasibility study

Questionnaire	Description	Period	T1	T2	T3
<i>PTSD checklist for DSM-V (PCL-5)</i> [Weathers et al., 2013]	The PCL-5 is a 20 item self-report measure that assesses the 20 DSM-V symptoms of PTSD and can provide a provisional diagnosis and/or determine mean change. The previous version of the PCL has been validated in over 20 studies, including with women in primary care, and found to have good psychometric properties (McDonald et al., 2010).	Last 30 days	X	X	X
WCDVS version of the Life Stressor Checklist-Revised (LSC-R) (McHugo et al., 2005)	The LSC-R is specifically tailored to trauma exposure and life events of women. It has demonstrated good content validity (Wolfe & Kimmerling, 1997) and criterion-related validity for PTSD in diverse populations of women (Brown, Stout & Mueller 1999; Kimmerling & Calhoun, 1999.). The modified version has been tested in a large sample of women (n=3,000) for tolerability and breadth and scope of possible traumatic events affecting women and showed good test-retest reliability (McHugo et al., 2005). This study created a further modified version for administration at the follow up time points, capturing the presence or absence of 31 life stressors since the previous assessment.	Lifetime & past six months	X	X	Shortened version - exposure count since last assessment
Composite Abuse Scale (Revised)—Short Form (CAS-SF) (Ford-Gilboe et al., 2017)	Comprehensive, valid and reliable brief self-report measure of 15 items capturing physical, sexual and psychological abuse and overall intimate partner violence. It retains the strengths of the longer 30 item CAS (Hegarty et al., 2005) and has been tested in a large sample of Canadian women (Ford-Gilboe et al., 2017). Authors currently recommend using a total score of all 15 items reflecting overall severity. An adapted version was used at the follow up points, to ask about the presence of the 15 items of abuse since the last assessment, as well as frequency.	12 months + 1 month (T1)  Since last assessment and 1 month (T2 & T3)	X	X	X
<i>Brief version of the Posttraumatic Cognitions Inventory—(PTCI-9)</i> (Wells et al., 2017)	The full version of the PTCI has demonstrated good psychometric properties in mixed trauma samples (Foa et al., 1997) and with women who have experienced sexual assault (Andreu et al., 2017) and used with samples experiencing co-morbid PTSD and alcohol problems (Foa & Williams, 2010). A shortened 9-item version has recently been developed and showed strong correlation with the full inventory among a group of female participants with and without PTSD (Wells et al., 2017).	N/A	X	X	X
<i>ASI –Drug composite and ASI-Alcohol composite scores of the Addiction Severity Index</i> (McLellan, 1980).	The composite scores are based on reported use and perceived problem severity during the past 30 days. They have been found to be a reliable and valid measures of current patient status (Comfort et al., 1999; McLellan et al., 1985;). Studies of women and psychiatric patients have reported favorable test-retest reliability and internal consistency [Comfort et al., 1999, Hodgins & el-Guebaly, 1992).	Last 30 days	X	X	X

The Patient Health Questionnaire (PHQ-9) (Spitzer et al. 1999)	The PHQ-9 is a self-completed measure of depression widely used in the UK (Spitzer et al., 1999) aligned to the diagnostic criteria for depression and has extensive validation in diverse populations with sensitivity to change (Gilbody et al., 2007).	Past 2 weeks	X	X	X
The Difficulties in Emotion Regulation Scale (DERS) –Short Form (Kaufman et al., 2015)	DERS is a well validated and widely used self-report measure for assessing emotion regulation problems in adults (Gratz & Roemer, 2004). A shortened version comprising 18 items has been developed and shown to have excellent psychometric properties, retaining the total and subscale scores of the original measure with half the items (Kaufman et al., 2015; Victor & Klonsky, 2016).	N/A	X	X	X
Rosenberg Self Esteem Scale (RSE) (Rosenberg, 1965)	The RSE is one of the most widely used measurements of self-esteem and comprises 10 self-report items. It has shown high internal reliability among female survivors of sexual or physical abuse (Kubany et al., 2004)	N/A	X	X	X
Social Provisions Scale (SPS) (Cutrona & Russell, 1987)	SPS is a self-report measure of 24 items covering 6 different areas of social support provision which respondents' rate on a four-point scale. The SPS has shown good reliability and validity among students and professional groups (Cutrona & Russell, 1987)	N/A	X	X	X
Core Components of Treatment Scale (Coping Skills) (Najavits et al., 1995) – Modified version	This scale is an adapted version comprising a self-report measure of 18 different coping skills taught in the Seeking Safety intervention and has shown good internal consistency with this study population (Gatz et al., 2007).	Past 30 days	X	X	X
California Psychotherapy Alliance Scale (CALPAS-G) for groups (Gaston & Marmar, 1994)	The CALPAS-G is a 12-item measure of group alliance and cohesion which is closely aligned to the widely used CALPAS used in individual therapy. The CALPAS has shown good internal consistency and inter-rater reliability (Cecero et al., 2001; Fenton et al., 2001) and the CALPAS-G has been shown to effectively assess group cohesion in patients with depression (Crowe & Grenyer, 2008).	N/A		X	
Hatcher-Gillaspy Short Form of the Working Alliance Inventory (WAI-SF) (Hatcher & Gillaspay, 2006)	The WAI-SF is an adapted version of the original WAI (Horvath, 1981) and consists of a client version (12 items) and corresponding therapist version (10 items). It has shown good internal consistency and high reliability (Hatcher & Gillaspay, 2006; Munder et al., 2010)	N/A		X	

### 6.6.1 Process evaluation measures

Participants were asked to complete a service receipt inventory at T2 and T3 to reflect health and social care services received since the last assessment including: quantity of sessions and total hours spent with practitioners (such as key-workers, one-on-one counselling), other group-work programmes attended, and referrals to internal/external services. Six summary variables were created (Appendix 21).

I completed case management forms after each session in conjunction with one of the group facilitators at the end of each session and detailed any areas of concern such as substance use, disclosure of self-harm/suicidal thoughts, or reports of other adverse events that should be shared with the key-worker. Reasons for non-attendance were recorded by the group facilitators.

A brief feedback form (5 mins) for participants available in the manual (Najavits, 2002) was completed immediately at the end of each session. Participants were asked to rate each session on a Likert scale of 0-3 on helpfulness of session in the domains of topic, hand-outs, quotation, therapist, session, and helpfulness for addressing PTSD symptoms and substance use. A mean score for each of these domains was calculated for each session.

A shortened version of the Seeking Safety Feedback Questionnaire, available in the manual (Najavits 2002) was administered at the final session which asks participants to rate, on a Likert scale from -3 to +3, the helpfulness of different aspects of treatment: *safety as the priority of treatment, integrated treatment, focus on abstinence, focus on ideals, focus on learning coping skills, length of sessions, amount of written material, language of handouts, and structured approach*. A mean score was calculated for each of these domains.

All group-work sessions were video-recorded and observed and assessed for fidelity against The Seeking Safety Adherence Scale (Najavits, 2003) (Appendix 16). This scale comprises of 21 sections covering: *Format* (check-in, quotation, handouts, check-out); *Content* (e.g., focus on trauma/PTSD, safe coping, topic discussion and rehearsal); *Process* (e.g., warmth and caring, building group cohesion); and an overall score for performance. Each section requires two ratings

of between 0-3 for 1) adherence and 2) helpfulness; and allows for qualitative descriptions of strengths and weaknesses of facilitators to be noted.

## **6.7 Data Collection**

### **6.7.1 Trialling the structured questionnaires**

The baseline assessment was tested with one of the service users from the Steering Group (Chapter 5). As a result, the following adaptations were made relating to the method of administration:

- introductory paragraph to be read by the questionnaire administrator which outlines briefly the number of questionnaires and areas covered;
- option to self-complete or to have questionnaires read out aloud by the administrator;
- provide written card prompts with the Likert scale answer options for use by participants when the questionnaire is read out;
- when switching between time periods in the WCDVS Life Stressor Checklist (i.e., from childhood to entire lifetime), reiterate when the question refers to the entire lifetime;
- after the WCDV questionnaire, ask about participants' welfare and provide with the option to take a break, before continuing.

### **6.7.2 Quantitative data collection: structured questionnaires**

Participants were invited to take part in three face-to-face research interviews at three different time points, based in a private room at the study treatment service or at another service they were accessing at the time, with support staff available as needed. These interviews took place: i) between 1-14 days before the start of the first group-work sessions (T1); ii) between 1-14 days after the last group-work session (T2); and iii) 3-months after the final group-work session (within a 1-14 day week window) (T3). The interview involved participants completing a set of structured questionnaires comprising the measures detailed in Table 9 above. The PCL-5 was self-completed by the participants and the IPA questionnaires (WCDVS LSC-R and CAS-SF) and I administered the ASI- Drug and Alcohol questionnaire. Participants were then given the option for self-completing the remaining questionnaires or having them administered by myself, and

most opted for latter. A shortened version of the WCDVS LSC-R was administered at both follow-up points, capturing the presence or absence of any new forms of life stress and trauma, since the last assessment. It was presented as a list of 31 items and participants were asked to give me the item number of any that applied. This was quick and easy to administer and appeared to cause minimal distress. The semi-structured interviews provided opportunity to follow up with any positive responses given to IPA.

Following an ethics modification approval (sec 6.9.1) in Nov 2017, participants in Group 2 were offered the option of their T3 interview to take place at home or another location of their choosing. This was because of the service closure, which happened on the 31 March 2018.

### **6.7.3 Qualitative data collection**

Two forms of qualitative data collection were selected in order to best capture the richness and depth of participant experience.

#### **6.7.3.1 Focus groups**

Focus groups were chosen in order to use the interaction of the group to generate data, allowing participants to listen, respond and revise their views, and to take more of an active part in leading the 'interview'. This was thought to be particularly useful for generating consensus about group format issues and recommendations for changes. It can present a more natural environment because participants are influenced by, and influence, others, just as in real life (Kruegar & Casey, 2009, p.7). The focus group was also deemed appropriate because participants would be familiar with each other by the end of the final group session.

I facilitated two focus groups with group-work participants: one after the final session of each of the two groups, lasting 50 and 75 minutes respectively. The questions followed a topic guide (see Appendix 23) devised jointly by myself and KT & GG, and questions focused on the participants' views on recruitment (e.g., motivations for attending, thoughts on recruitment materials); experiences of the group (e.g., core concepts of treatment, format, facilitators); and the impact of the group on their recovery (e.g., any noticeable differences, how the group helped, ability to put

coping skills into practice). Four women from Group 1 who were not able to attend the focus group were asked some general questions at their post-intervention follow up (T2) based on the topic guide. A total of 13 women participated in the focus groups (7 from Group 1 and 6 from Group 2). Both focus groups were audio recorded and transcribed verbatim and where participants were identifiable, their IDs were used.

As anticipated, the focus groups provided opportunity for participants to respond to each other's views, either corroborating and reaching a group consensus, or arguing and challenging each other. In both focus groups, participants directly asked questions of each other and made suggestions or comments which would not have been elicited in individual interviews. Some examples of this are presented in the Results (Chapters 7 & 8).

As the facilitator of the focus groups, I was also able to glimpse a sense of the differential group bonding and dynamic between Group 1 and Group 2. For example, in Group 1, participants stopped the focus group part way in order to present me with flowers and a card signed by all members of the group, as a show of gratitude for being involved in the study. In Group 2, the dynamic appeared less warm. This was due particularly to the presence of one woman, who left after 20 minutes after sharing negative views of the intervention, after which the remaining participants spoke disparagingly about her. It led into a wider conversation about their experience of the group dynamic in general during the sessions, useful data in itself.

#### **6.7.3.2 Semi-structured individual interviews**

The method of individual interviews was chosen in order to allow more in-depth questioning to, 'get below the surface' (Yeo et al., 2014) and provide space to discuss more personal issues and explore individual circumstances. The semi-structured questions allowed for more flexibility and responsiveness to participant comments, in comparison to the structured interviewing (Bryman et al., 2012). It also provided the opportunity to follow up on responses to the structured questionnaires in order to gain more explanation and context.

At the 3-month post-intervention follow-up (T3), all Group 1 participants were asked if they would

like to take part in an extended final interview following completion of the quantitative measures. This comprised of a semi-structured qualitative interview with myself (which lasted between 20-40 minutes), in addition to the structured questionnaires. The topic guide (Appendix 24) comprised five domains: experiences of undertaking the assessments (e.g., language in the questionnaires, emotional responses); reasons for attendance or non-attendance at the group (e.g., barriers/facilitators to attendance); experiences of recovery since ending the group (e.g., any changes to substance use or PTSD symptoms, coping skills used); safety issues (e.g., follow up probes from any IPA indicated in the measures and safety skills); and thoughts on measures/outcomes (e.g., relevance). Some women used the opportunity at their T2 interview to express an alternative view to that expressed in the focus group, which they had felt unable to share at the time. The interview also provided opportunity to explore more delicate subjects, which may have caused discomfort discussing in a group format.

#### *6.7.3.2.1 Amendment to the timing of the qualitative interviews*

Based on the experiences with Group 1, the timing of the semi-structured interview was revised for Group 2 participants with ethical approval (see section 6.11.1). These changes were sought due to the information that participants were voluntarily offering up during the completion of the structured questionnaires, best captured in a semi-structured interview. Furthermore, it became apparent that questions regarding group format were best asked immediately following the end of the group and not 3-months later. Therefore, all Group 2 participants were invited to answer a set of semi-structured interview questions both at T2 & T3. With this amendment, the interview topic guide was essentially split so that T2 focused on experiences of the group, barriers/facilitators to attendance, and helpfulness for. The interview topic guide at T3 focused on the experiences of undertaking the assessments, thoughts on measures, safety issues experienced during the group and since the last assessment, and changes to PTSD symptoms, substance use, and coping skills used.

All interviews were audio recorded and transcribed verbatim. A total of 15 women agreed to participate in the individual interviews. Three of the women not interviewed attended one of the focus groups.

#### *6.7.3.2.2 Participant re-imbursement*

All participants were given £15 shopping vouchers for each completed interview and focus group, in recognition of the time required to attend interviews. Women who identified travel costs as a barrier to attending interviews were reimbursed for their travel by the study treatment service.

Researcher field-notes taken at the time of the interview noted that many women were appreciative of the vouchers, a point echoed by the service manager when interviewed:

“I don’t think it was huge resources was it, but the women, for them it was huge, just getting a reward for something that is positive rather than getting a reward for something not positive, it has made all the difference.” (Service Manager)

#### *6.7.3.2.3 Group facilitators and service manager interviews*

The two group facilitators were interviewed together at their request. The service manager was interviewed separately. All interviews took place in March 2018 and were conducted by myself. The semi-structured topic guides included questions on their experiences of taking part in the study in terms of: the research process (motivations for taking part in the study, intervention review and collaboration, fidelity process); the group (format, structure and content, suitability for client group); organisational issues (managerial support, clinical supervision, staff skills); and recommendations for future roll-out (Appendices 25 & 26). All interviews were audio recorded and transcribed verbatim.

## **6.8 Quantitative data analysis**

### **6.8.1 Data entry**

All data from the structured questionnaires were first entered into an excel spreadsheet and summary variables calculated as per Appendix 21. This data set was then imported into Stata 13.1. The following new variables were then created:

- Four new dichotomous variables using data from the WCDVS LSC-R to indicate the presence of childhood physical abuse, childhood sexual abuse and adult physical and sexual abuse;



- Binary variable for the presence or absence of new exposure to IPA since baseline at T2 and T3;
- Binary variable for 'depression caseness' representing those with a PHQ-9 score of more than nine (Kroenke et al., 2001);
- Binary variable for 'group-dose' representing those who attended six or more sessions (50%) and those attending less than six sessions (not including pre-orientation) ;
- Binary variable for those showing PTSD 'clinically meaningful change' based on change of 10 points or more (Weathers et al. 2013) at T2 and T3;
- ASI Drug and Alcohol Composite Scores based on guidance by McGahan, Griffith, Parente, & McLellan (1986).
- Two variables for days of drug and alcohol use in the past 30 days, based on the ASI.

### **6.8.2 Descriptive data**

Descriptive data relating to participant characteristics and baseline mental health, substance use and trauma histories were summarized using frequencies and percentages for categorical data, and means and standard deviations for continuous data:

- Six score variables were created for the data from the Seeking Safety Adherence Scale (Najavits, 2003) which measures facilitator adherence to the manual fidelity. They comprised the mean scores, for both 'Adherence' and 'Helpfulness' for each of the subscales of Format, Content and Process;
- Four score variables were created comprising the mean of each of the 4 subscales of the measure of group cohesion (CALPAS-G);
- Two score variables were created from the measure of therapeutic alliance (WAI-SF) using the mean participant scores for each of the two facilitators.

### **6.8.3 Statistical analysis**

Exploratory analyses of the variables related to substance use, PTSD, depression, emotional regulation, self-esteem, coping skills, and social support were carried out using 'Intention to Treat' i.e., collecting data from all participants regardless of how many sessions they attended. Mean variables at each time point were first examined for normality and symmetry visually using

histograms and box-plots and where there were concerns, the Shapiro-Wilk test for normality. Where there was uncertainty, for example in cases of large outliers, both parametric and non-parametric tests were run on the variables and if these both showed significant results ( $\alpha=0.05$ ) of a similar p-value, then the parametric test was reported. Where data was asymmetrical or involved a summary variable on the ordinal scale, non-parametric tests involving the medians were administered and results presented with the median and range.

#### **6.8.3.1 Measures of change over time**

For symmetrical data, a one-way repeated measures Analysis of Variance (ANOVA) test was undertaken using time as the independent variable. If the data did not meet the assumptions of sphericity (another test of normality) then the Greenhouse-Geisser correction was applied. If this test showed evidence for a difference in means over time, a post hoc test involving pairwise comparisons using the Bonferroni correction (using  $\alpha = 0.017$  to avoid type 1 error when multiple tests are being applied) was run, in order to identify at which time points the change was experienced.

For asymmetrical data, the Friedman test was administered (dependent samples) to identify if there was change in median scores over time. If significant, a post-hoc test in the form of the Wilcoxon Signed Rank test was carried out for each of the three paired time points.

#### **6.8.3.2 Missing data**

For participants who were deemed lost to follow up, the last set of data collected was used in place of missing data at T2 and T3. Known as 'Last Observation Carried Forward' this is a commonly used technique in clinical trials (Bell, Fiero, Horton, & Hsu, 2014). Where there were missing items from a measure, the score from this item was omitted from the total or mean score. This happened on three occasions in the entire data set: once for an item on the PHQ-9 and twice on the PCL-5.

## **6.9 Qualitative data analysis**

### **6.9.1 Data set**

The data set comprised 26 separate transcripts that were analysed together. This comprised transcripts from each of the focus groups and transcripts of interviews from 15 separate women (Group 1=7, Group 2=8); 15 interviewed 3 months post-intervention (T3) and nine interviewed at immediately post-intervention follow up (T2) (eight from Group 2 and one woman from Group 1 who was unable to attend the focus group). One woman was interviewed in prison at T3, and because audio-recordings were not allowed due to prison regulations, hand-written notes were taken which were included in the analysis in place of an audio-transcript.

### **6.9.2 Data analysis**

All data were uploaded to NVivo 12 for data management and preparation for analysis.

#### **6.9.2.1 Participant attributes**

As part of the 'Framework' approach (Ritchie et al., 2014), three 'attributes' were chosen to assign to the participants ('case classifications' in NVivo) based on variables created in the quantitative analysis (sec 6.8.1). This allowed for sub-group analysis of the qualitative data later in the process. The attributes were: 1) minimal dose exposure (attending any six sessions or more); 2) attendance in the first or second group (Group 1 or 2); and 3) clinically meaningful change in PTSD at T2 and T3. The justification for choosing session dose was the hypothesis that those attending more sessions may demonstrate greater insights into the intervention content as well as positive changes from participating in the group. The separation of participants by Group 1 and Group 2 was chosen because the group-work facilitators were more familiar with the material in Group 2, which may have impacted participants' experiences. The attribute of PTSD change aligns to the seventh research objective of the study. It was also chosen to explore if there were any patterns in the data, which could point to components of the intervention, or potential active ingredients, which may contribute to PTSD symptom improvement.

### **6.9.2.2 Thematic Analysis**

Thematic analysis using framework (Ritchie et al., 2014) was employed because it provides structured and clear guidelines for the researcher. Framework also fits well within a critical realist approach in that it seeks to explore the meanings, experiences and the reality of participants (Braun & Clarke, 2006). The use of frameworks to manage the data allows for easy movement across the whole data set to explore patterns in the themes across different participants and groups of participants and linkage of phenomenon within individual participant transcripts. In addition, providing examination of the data according to pre-defined participant attributes is particularly useful in a mixed-methods research design. The framework approach contains the common elements found in thematic analysis in terms of summarising the data to 'consciously process it', labelling or coding words or phrases 'in-vivo' (i.e., inductively) or as emergent concepts devised by the researcher (i.e., deductive), in order to capture 'an important moment' (Boyatzis, 1998). The steps undertaken for the analyses are outlined below:

#### *6.9.2.2.1 Data familiarisation*

This stage involved my full immersion in the data, beginning with transcription and continuing with re-reading the transcripts and noting any re-occurring themes and topics of interest that were relevant to the research questions. This included more interpretative ideas, for example, the issue of time-pressure and censoring of speech impacting on the group dynamic, and the discrepancies between the concerns the facilitators held about the material prior to the group commencing and the views of the participants themselves.

#### *6.9.2.2.2 Constructing a thematic framework*

A hybrid approach (Fereday and Muir-Cochrane, 2006) was undertaken, allowing for both inductive and deductive labelling/coding. The familiarisation stage elicited a long list of codes from the transcripts either using the actual words or phrases in the data or using a new code that I defined, often closely aligned to the study objectives or topic guide. This formed an initial 'code-book' which was sorted into initial hierarchies of themes and subthemes (the 'framework'). Nine over-arching themes were constructed for this initial stage. This is illustrated in Appendix 27.

#### 6.9.2.2.3 Indexing and Sorting

At this stage chunks of data were coded sequentially in NVivo by applying the framework and codebook. This was followed by a review of all the data indexed to each code in the framework, with an eye on reviewing, merging and dividing codes to make a more coherent sorting process. At this stage the three separate sub-themes relating to *missed sessions* were merged under the theme of 'Attendance' and the initial sub-themes of *problems with other services* were merged with *other interventions* under the higher theme of 'External Influences'.

#### 6.9.2.2.4 Data summary and display, using Framework

A final stage of the data management process involved investigating in more detail what each participant said about each of the themes. Using the technique available in Nvivo 12, each of the eight over-arching themes were transformed into a matrix that displayed the corresponding sub-themes in columns against each participant 'case' assigned to the row. The transcripts from the focus groups were each treated as a case for the purpose of the matrix. These were each saved in an excel file. In line with the analytical guidelines, each matrix cell containing data was then summarised, keeping to the language of the participants as close as possible, and including pertinent original quotes (in italics), and underlining analytic thoughts (Ritchie et al., 2014). Assignment of the participant IDs used in the focus group transcripts were maintained. These summaries were saved as new matrices in order to preserve the raw data for reference later.

#### 6.9.2.2.5 Constructing categories

Through all the previous stages, the process of abstraction was taking place, as I kept notes for more analytic themes, involving interpretation or evaluation. However, this next stage established the more formal move from descriptive to interpretative analysis. Firstly, within each of the eight matrices, representing the over-arching themes, each piece of data summary was re-read to establish the 'detected elements.' This is a term used in framework for the process of more detailed 'in-vivo' coding to try and reflect 'what is happening within a sub-theme' (Ritchie et al., 2014, p.311). It attempts to capture the views, perceptions, experiences and/or behaviours identified in the summaries and list the elements present. These were then listed in a new column. Elements perceived to 'be about the same thing' were then grouped together in 'key dimensions'

using Word, maintaining the initial themes used in the matrices, as well as participant IDs, and their assigned attributes (see section 'participant attributes'). An example of this is found in Appendix 28 which contains the detailed excerpt from the same theme 'Research Process'. Note that the same detected element may appear in more than one 'key dimension' and minority views, even if only stated by one participant can become a key dimension.

#### *6.9.2.2.6 Cross validation*

At this stage a level of cross-validation took place with a second researcher (GG) who read all the Word documents containing the 'detected elements' and 'key dimensions' and suggested re-grouping, merging or new developing new 'key dimensions.' Examples of some of the changes adopted as a result of this cross-checking were: clearer classification of positive and negative responses; merging of some key dimensions related to mental health, as they were deemed to be about the same thing; and creation of 'being ready' as a new dimension. Appendix 29 summarises the key dimensions established for each of the themes after the cross-checking process.

#### *6.9.2.2.7 Categorisation and classification*

The final stage of the interpretation process involved reference back to the initial research objectives and mixed-method design in order to create groupings of the 'key dimensions' that have the same underlying dimensions, known in framework as 'categories'. For this stage I drew on the use of visual mapping (Figure 13) using flipcharts and post-it notes in order to move around the key dimensions to form new groupings, and devise more abstract concepts, which I called themes and sub-themes.



Figure 13: Mapping used to devise the final set of themes in the analysis of participant interviews

The final sets of sub-themes were both descriptive (e.g., clinical supervision, format of group) and more interpretative or abstract in nature (e.g., opportunity for reflection, emotional intensity, resource intensive). These were grouped in over-arching themes which were mostly descriptive in order to align to the initial research objectives i.e., research measures, fidelity etc. Where appropriate the sub-themes were also grouped according to whether the participant attributes were found to influence the sub-themes, a methodology also common to the framework approach (Ritchie et al., 2014, p.321). This latter process required a return to some of the earlier framework matrices containing participant IDs. Appendix 30 illustrates the final set of themes and sub-themes.

## 6.10 Mixed methods data analysis

Chapter 2 outlines how the concurrent design of the feasibility study allows for the merging of quantitative and qualitative data to answer the research questions, guided by the classifications of Bryman (2012). Appendix 30 outlines how the different data collected were linked together for presentation in the final results. The analysis of the mixed-methods data involved a highly iterative

process whereby parts of the quantitative data analysis took place first to inform the qualitative analysis (e.g., assigning the attributes), before returning to the quantitative data analysis after a long process of qualitative analysis, in order to 'confirm and discover' new hypotheses formed.

#### **6.10.1 Confirm and Discover: quantitative analysis informed by the qualitative data**

The assignment of the attributes, relating to group dose and PTSD change, to the qualitative data helped to devise new hypotheses to explore in the quantitative data. The impact of group dose and exposure to new IPA, both categorical variables, were included separately in the repeated measures ANOVA, in order to explore whether they interacted with time on the PTSD outcomes. Both these additional variables passed assumptions related to sphericity (Mauchly test) and homogeneity of variances (Levene test), which are necessary for this form of analysis to be used.

Differences between groups at one time-point were explored using two tailed paired T-tests, after assessing for equal variances, or Wilcoxon signed rank test for asymmetrical data or ordinal measures. Correlations between variables were explored using Pearson's Correlation Co-efficient or Spearman's Rank Correlation for ordinal data or where a linear relationship is not apparent. Co-efficients of between  $\pm 0.5-1$  were interpreted as large associations.

#### **6.10.2 Completeness and Triangulation**

Qualitative data were combined with the quantitative data relating to group attendance, study retention rates, fidelity monitoring scores, and session feedback questionnaires in order to provide a more complete description of acceptability. In some cases, the quantitative and qualitative data were 'triangulated for corroboration.

#### **6.10.3 Explanation**

Qualitative data were used to explain some of changes over time in the outcome variables relating to substance use, PTSD, and emotional wellbeing.



#### **6.10.4 Context**

Qualitative data relating to social support, wrap-around services, and experiences of new IPA since baseline were used to provide further contextual descriptions of reasons for recovery or relapse.

#### **6.10.5 Addressing ‘validity’ in mixed methods design**

Within the context of a mixed methods design, the ability to draw meaningful and accurate conclusions from the merging of the data sets is important. The ‘validity’, sometimes referred to as ‘inference quality’ (Tashakkori & Teddie, 2010), was considered in the context of the individual qualitative and quantitative data collection and analyses processes, and is discussed more in Chapter 9. However, attempts to minimise the threat to validity in the mixed methods design also involved the following additional considerations:

- The quantitative and qualitative samples were drawn from the same population and attempts to attain a diverse qualitative sample reflective of the entire sample;
- Re-examination of data where contradictory results were identified across the qualitative and quantitative data sets.

## **6.11 Ethics and participant and researcher safety**

Ethical approval for phase 4 of the PhD study was granted on the 14 June 2017 by the Psychology, Nursing and Midwifery Research Ethics sub-committee at Kings College (Ref: HR-16/17-4598) (Appendix 31).

### **6.11.1 Amendments approved**

Following this approval, the following modifications were requested and approved by the sub-committee

- 29.08.17. Approval granted to amend the duration and sequencing of the group session, include a pre-orientation session, and change the recruitment poster to stress that the group will not require talking about trauma in detail;
- 13.10.17. Approval granted to video-record the session upon receipt of additional informed consent from group participants;
- 29.11.17. Approval granted to administer amended questionnaires at T2 and T3 and include an extra questionnaire on therapeutic alliance, as well as permission to undertake T3 assessments at participants' homes or other safe locations due to the announcement of the service closure;
- 06.02.18. Approval granted to undertake qualitative interviews at T2 not only T3;
- 16.02.18. Approval granted to share a selection of the video-recorded sessions with the intervention author Lisa Najavits, to help with the fidelity monitoring process. Additional written consent from participants were obtained;
- 13.06.18. Approval granted to interview a research participant in prison.

### **6.11.2 Informed Consent**

Informed consent was obtained from the participants at the screening stage and each subsequent assessment interview. I have received training in the ethical principles underpinning informed consent, as part of my MSc course, and felt able to assess potential participants' capacity to consent. All potential participants were given a written information sheet (Appendix 18) by myself or service staff at least 24 hours in advance of their screening assessment and I also summarised

its contents verbally at the screening assessment. Participants were informed of the voluntary nature of their participation and rights to withdraw from the study at any time and their data erased up to a given date (focus group data – four weeks afterwards; all other data up until 31 May 2018). They were given the opportunity to ask any questions about the research, the consent process, and limitations to confidentiality. They were required to sign a consent form (Appendix 19) including a statement on limitations to confidentiality, countersigned by the researcher, and a copy provided for their records.

Following consent, the researcher collected written secure contact details from the participant. This contained direct contact details for the participant, an additional named safe contact (optional), and a preferred contact method. Where an appointment was made to conduct the research interview at a future date, participants were contacted in advance as a reminder, but also to check their continued willingness to participate in the research. One screening interview took place by telephone; informed consent procedures were explained verbally and the consent form signed at the beginning of the baseline interview.

One research participant was deemed to be unable to give informed consent, possibly due to intoxication. In this case an arrangement was made to contact the participant the next day, and another meeting took place the following week.

### **6.11.3 Confidentiality and data protection**

All participants were assigned a unique ID number that was used on all paperwork (except the consent forms) and in the storage of electronic data. Data that included identifiable details about study participants (e.g., contact details) were stored separately from the research data. The contact details collected from participants were entered into an excel spreadsheet as soon as possible following the screening interview, and the paper copy shredded. The spreadsheet containing personal information was stored with password protection on a secure server at KCL and backed up in two secure locations: 1) Apple Mac computer based in the office at KCL that encrypts documents and requires ID and password to access the computer, and 2) an encrypted and password protected USB stick kept in a locked filing cupboard at the office.

Personal identifiable data from interview transcripts relating to names, services, and geographic locations were removed during transcription. A digitally encrypted audio-recorder with password protection was used to record all interviews, except in the case of the one interview that took place in prison, where hand-written notes were taken. Following interviews, all paperwork was returned to KCL and stored in a locked filing cabinet and audio-recordings uploaded to the computer, password-protected and deleted from the digital recorder.

The video-recordings of the session were collected immediately following the end of each session, stored on an encrypted and password protected USB stick and deleted from the video-recorder. The USB stick was immediately returned to KCL and stored in a locked cabinet. Due to their large file size, the videos were unable to be stored on KCL's secure server. Phone numbers were stored on an Apple iPhone with password protection and encryption and kept in a locked cupboard when not being used.

These processes were reviewed as part of KCL's registration process for the General Data Protection Regulation (GDPR) in May 2018 and entered into the KCL Data Protection Database on 17/05/18 (ref: DPRF-17/18-6782). I also completed the associated KCL online GDPR training in May 2018.

#### **6.11.4 Limitations to confidentiality**

Participants were made aware of the limits to confidentiality in terms of passing information on to a third person. The following procedures were followed.

In the event that a participant expressed current/future intent to harm themselves or others (including children) or disclosed experiencing current abuse harm or neglect at the hands of another (e.g., positive answers to intimate partner abuse in the CAS-SF), information was reported to study treatment service staff (or other partner service responsible for coordinating care if interviews took place elsewhere). On the occasions this happened, all participants gave permission for this information to be passed to their key-worker. Service staff were then obligated to follow their usual safeguarding protocol under their duty of care. The London Borough where

the study took place have a 'consent to liaise' form which allows service users to give consent for their information to be shared with local named agencies in the borough.

If any disclosures took place, I took the following steps, as appropriate:

- stopped the interview and provided sympathetic and non-judgemental recognition of any emotional distress the participant was expressing; offered the option to continue the interview another time, a cup of tea or time to have a cigarette;
- if issues were raised regarding self-harm or suicidal ideation, asked if the participant was willing to give more details, and probed about the potential future timeframe for any suicide attempts; or alternatively if the participant did not feel like talking anymore, explained that service staff member would speak to them about what they have said;
- informed the participant that what they had said needed to be shared with their key worker;
- gave details of local and national sources of support and checked whether it was safe to take this home;
- discussed the nature of the disclosure with the key/duty worker as soon as possible (same day where possible);
- safeguarding issues discussed with the group-work facilitators if needed;
- in all cases where a serious risk or adverse event was identified this was recorded, together with the action taken, in the research incident form.

Three incidents regarding risk of harm to self by others were recorded during the study period and four reports of risk of self-harm. In all cases the procedures were followed, and the course of action taken by the key-worker, if known, was noted. In the case of the participant in prison at T3 (sec 6.11.5), the lead psychologist for the Women's Prison Estate was alerted. No disclosures took place regarding abuse, harm or neglect of a child, either perpetrated by participants themselves or another person. One adverse event, potentially related to participation in the study, was recorded. This was discussed with my PhD supervisors and a Serious Adverse Event Form submitted to the KCL Research Ethics office for consideration. The internal audit of this event is discussed below.

#### **6.11.5 Internal audit – serious adverse event**

One adverse event was recorded at T3 and involved one participant being imprisoned accused of Grievous Bodily Harm. The participant had requested that her study data were released to her solicitor. A Serious Adverse Event form was submitted to the KCL research ethics office (reported in Results, sec 7.4) and it was determined that a 'for-cause audit' should be carried out. This took place on the 13 July 2018 with the following remit:

- i) to explore if any part of the study contributed to the adverse event
- ii) to identify any breaches to the ethically approved protocol
- iii) to identify if the sharing of data could put the researcher at risk of harm or cause reputational risk to the university.

The conclusions of the audit were that there were no critical, major or minor findings that required addressing. In fact, the audit author stated:

“The conduct of the research has been to a high standard and the ethically approved protocol has been clearly followed, particularly in relation to the risks related to the target demographic, data has been appropriately managed and all modifications have been submitted for ethical approval. The development of the research project is, in my opinion, exemplary as the majority of the modification requests made since full approval are changes made through points of learning while the project is live and the researchers attempt to improve the research, both for participants and to ensure the highest quality of research. This also indicates the researcher’s engagement with the ethical approval process and efforts to conduct her research to the highest standard of integrity.”

Upon the request of the participant, I passed the information of the adverse event to her ex-key-worker who was working at the newly commissioned substance use treatment service in the borough.

#### **6.11.6 Safety in communication with study participants**

Procedures for making contact with participants followed those outlined in the Standard Operating Protocol for intimate partner violence established by the Section of Women’s Mental Health at

KCL, in order to assume maximum safety. The key parts relevant to this study are listed in Appendix 32.

#### **6.11.7 Minimising distress from participating in the study**

It is normal for some participants to become emotionally upset when discussing trauma experiences. The potential for the interview to bring up distressing memories or feelings was described in the Participant Information Sheet. I always ensured that an appropriate staff member was aware of the interviews taking place and available on site in order to provide support to the participant during or post-interview if required. On the two occasions where the interview took place in a venue other than a support service (once over the phone, and once in a café), the service manager at the study treatment service was made aware of the interview time and made herself available by phone should she be required by either the researcher or participant following the interview. At the beginning of each interview, I reminded participants that they would not be rushed into answering questions and could refuse to answer any questions.

I have over 10 years' experience working in the field of domestic violence and interviewing survivors of abuse and was confident about procedures for minimising risks (both psychological and physical) as much as possible. The attitude of the researcher in terms of how questions are framed and responses to disclosures of abuse or other trauma can play a key role in minimising distress. A skilfully conducted interview can be a positive intervention for the participant (Scerri, Abela &, Vetterre, 2012; Vearey, Barter, Hynes, & McGinn, 2016;). Process evaluation involved asking participants how they found the interviews in terms of distressful and/or positive experiences.

Following the completion of the first set of baseline interviews with participants, I felt I needed support to mitigate against the effects of vicarious trauma (Herman, 1998), and therefore clinical supervision from a KCL clinician was provided monthly for the remainder of the study.

## 6.12 Limits of the feasibility study design

This phase of the PhD study attempted to answer some fundamental uncertainties about the feasibility of delivering a US intervention within routine substance use treatment practice in England. However, the proposed study design would leave a number of important parameters unanswered requiring a next stage feasibility study (Eldridge et al., 2016) before a randomised control trial (RCT) could be considered. These include the:

- ability to assess willingness to be randomised to intervention or control group and study attrition for the control arm;
- calculation of measure of standard deviation to inform the sample size required for a future RCT;
- indication of travel of treatment efficacy. Although measure of treatment effectiveness is not the purpose of any form of feasibility study, the inclusion of a randomised control group would provide a better indication of travel with regard to potential effectiveness, compared to the within-subjects measure analysis. The quantitative analysis in this study only explored if there were any changes over time among the participants and could not make any claim about the role of the intervention. Regression to the mean also exists as serious threats to causal claims in single group pre-post-test designs (Marsden & Togerson, 2012; Marsden et al., 2011) and is discussed further in Chapter 9.



## Chapter 7: Feasibility Study Results: part one

The results are presented in two parts. Part one presents the qualitative and quantitative findings for the study objectives related to: 1) the ability to recruit sufficient numbers of study participants meeting the eligibility criteria and retain them, both in terms of adequate attendance in the group, as well as participation in the follow-up interviews (objective 4i); 2) the suitability and acceptability of study outcome measures to group participants (objective 4iii); 3) the required training and supervision to support facilitators to adhere to the fidelity of the intervention (objective 4ii); and 4) the acceptability and perceived helpfulness of the intervention (objective 5). These data combine the perspectives of the participants, group facilitators, and the substance use treatment service manager. Part two presents the exploratory analysis of participant outcomes at the end of the intervention (T2) and three months thereafter (T3) (objectives 6-7); and explores/discusses the wider contextual considerations that may have impacted on these outcomes (objective 4vi).

Quotes from interview participants are followed with a descriptor comprising [Name<sup>38</sup>, Group 1 or 2, number of sessions attended, and whether clinically meaningful improvement in PTSD symptoms (>10 point change) was recorded at T2 & T3].

### 7.1 Feasibility of recruitment, retention and study measures

In this section, the qualitative data, in the form of interviews and researcher field-notes, supports the retention figures, to provide a more comprehensive picture of women's motivations for taking part, reasons for missed sessions, and acceptability of measures, in order to support future recruitment and retention efforts.

---

<sup>38</sup> Participants real names have not been used in order to protect anonymity. Names preceded by 'FG' represent quotes taken from focus groups

### **7.1.1 Recruiting participants**

Recruitment for the feasibility study took place between 7 October 2017-11 January 2018. The intervention was delivered twice. The first group was completed and evaluated prior to the second group starting. Recruitment for the first group took place predominantly in the study treatment service and involved the active participation of the female service user representative (from the initial project steering group, see Chapter 5), and three staff from the study treatment service (the group facilitator and two female key-workers). Two recruitment sessions took place in early October 2017, attended by a total of 13 women. Over the course of the entire recruitment period for group one, staff directly contacted 15 women, who agreed for their contact details to be passed onto me to talk to them about the study in more detail.

In addition to recruitment at the study treatment service, attempts were also made to recruit eligible women from partner substance use treatment, domestic violence, and homeless services in the borough for Group 2. Initial contact was made with identified service leads from four services in the borough (all non-NHS) in October 2017: a second drug treatment and prescribing service, a specialist alcohol service, a domestic violence service, and supported housing service. Buy-in varied across these services in terms of allowing recruitment of their service users to the study. Following numerous phone-calls, the distribution of recruitment material, and offers to run a session at the partner services to talk to service users, three services agreed to take part. The reasons for non-participation by the specialist alcohol service were primarily due to the instability created by the re-commissioning of all substance use treatment services in the borough, which was taking place at the time.

Two service leads (from domestic violence and housing services) suggested that in addition to distributing the recruitment posters, they would review their caseloads and make initial approaches to women they thought may be eligible. It is unclear how many caseloads were reviewed but unfortunately, this resulted in only two women expressing initial interest in the study, both based at the housing service. The service lead at the partner drug treatment service organised an information session held at their premises, which I attended on 11 December 2017. However, despite the lead's best efforts only one woman attended.

In total, 38 women were approached to take part in the study of whom 30 completed the screening interview to assess for eligibility.

#### **7.1.1.1 Motivations for taking part**

In the qualitative interviews, participants expressed two overarching motivations for taking part in the study, grouped into the interpretive themes of: 1) *self-understanding* and 2) *staff encouragement*.

##### *7.1.1.1.1 Self-understanding*

For some women the drive for self-understanding was related specifically to their trauma and PTSD. One woman had recently been diagnosed with PTSD, and another was unsure whether she was experiencing abuse from her son. Other perspectives suggested that some women had 'suspicions' that their experiences of IPA and substance use may be connected, and the recruitment literature and/or attendance at the informational sessions or conversations with key-workers confirmed this, and the appropriate 'fit' of the intervention. For example:

"I have always kind of known somewhere that I had those traumatic experiences and that, I mean I wasn't using it as an excuse to drink but you know I could maybe take the drink away, but that wasn't the complete answer, there was all that underlying...So when this came up I thought ah that's it all in one more or less...that's where I fit." (Rachel, Group 1, 3-sessions, PTSD improvement at T2 & T3)

Women also spoke more generally about seeking to understand their behaviour 'why they act the way they act', and reasons for their decisions, choices, and actions in life. This included seeking to understand their 'role' in moving from repeated abusive relationships, or why they were not able to love or care for themselves. One woman had recently been diagnosed with PTSD and was vocal about her need to change:

"Cause I felt I had to do something, I had to get an intervention somehow cause I was killing myself, do you know what I mean, and I just really needed something that was going to explain to me my PTSD, explain to me why I do stupid things, why I make rash decisions, why can I never love myself, can't care for myself." (FG\_\_Steph, Group 2, 9-sessions, PTSD improvement at T2 & T3)

#### *7.1.1.1.2 Staff encouragement*

For others, recommendations from staff at the study treatment service encouraged them to attend:

“For me, originally [Facilitator 1] was the one that came up to me...obviously there were things that she had picked up on like in women’s groups and stuff. But she came to me and said I think this will be really good and like spoke to me about it and then [key-worker] even mentioned it a little bit.” (FG\_Gina, Group 2, 8-sessions, PTSD improvement at T2)

“Mine was [key-worker] and [Facilitator 1] recommended the group because in September I was at a really, really low point. I am not there now, thank god, but that was my motivation, that was why.” (FG\_Beth, Group 1, 8-sessions, PTSD improvement T2 & T3)

The staff were familiar with the female client base in terms of knowledge about their past histories related to trauma and this proved fundamental to effective recruitment.

#### *7.1.1.1.3 Social services involvement*

Five women who took part in the group identified at baseline interview that they had current or recent social services involvement due to safeguarding concerns for their children. Two women were involved in active court assessment processes to either regain custody of their children or to have custody. In the former case, the participant was transparent about the fact that she chose to attend the group due to ‘*social services being on her back*’. Both women requested letters from the group facilitators regarding their participation in the course for presentation to the courts.

### **7.1.2 Feasibility of study eligibility criteria**

The study eligibility criteria are detailed in section 6.2 of Chapter 6. These criteria aimed to be as inclusive as possible in terms of women’s range and severity of PTSD symptoms and substance use, as well as definition of IPA, which extended beyond the criterion for the DSM-V definition of PTSD. Such wide criteria were informed by: 1) the uncertainty that there would be sufficient women who met strict DSM criteria for PTSD and substance use disorder, and 2) to reflect the characteristics of women in treatment, particularly given the findings from the formative work (Chapters 3 & 4) which identified that integrated trauma-specific interventions could benefit women with a range of PTSD symptoms and substance use severity.

Of the 30 women screened for eligibility, 9 (30%) did not meet the criteria. The most common reason was not meeting the determined threshold for PTSD symptoms (n=5), which required at least one symptom endorsed as moderate from each symptom cluster on the PCL-5. Other reasons pertained to English language proficiency (n=1), non-engagement with a substance use treatment service (n=1), and lack of availability for the start date of the intervention (n=2). All 21 women meeting eligibility endorsed a Criterion A trauma from the DSM-V checklist, suggesting the other assessments of IPA (e.g. answers to nine items from the WCDVS Life Stressor Checklist) were not necessary. Secondly, the majority of women (95%, n=18) met the threshold for PTSD diagnosis defined as endorsing a symptom as moderate or higher for 1 item in B&C items and 2 items in D&E items, along with a score of 33 or above on the PCL-5 (Weathers et al., 2013). The mean score of PTSD symptoms was 53.95 (SD 13.78). Two women reported a suicide attempt in the previous six months and one woman reported recent attendance at A&E with suicidal ideation. However, all women were keen to enter the study and key-workers agreed they were well enough to take part.

### **7.1.3 Ability to recruit target population: participant characteristics**

Table 10 provides an overview of the demographics and general background variables of the 19 participants recruited. The majority of women were aged 40-49 years (63%, n=12) and identified as heterosexual (84%, n=16). Forty-seven percent (n=9) identified as belonging to a Black or Minority Ethnic (BME) group. Ten percent of women (n=2) were not born in the UK nor had English as their first language. The most frequent highest education level achieved was GCSEs or equivalent (53%, n=10). The majority of women were single at the baseline interview (84%, n=16) and whilst the majority reported having at least one child (74%, n=14), only 28% (n=5) reported the presence of children in the home that were under the age of 18 years. Five women (28%) reported the loss of custody of a child by social services.

Table 10: Socio-demographics and general background characteristics of the study participants

<b>Demographics and general background variables</b>	<b>n=19 n (%)</b>
Age	
18-29	1 (5.26%)
30-39	2 (10.53%)
40-49	12 (63.16%)
50-59	4 (21.05%)
Sexual orientation	
-Heterosexual	16 (84.21%)
-Bi-sexual	3 (15.79%)
Highest education received	
- No qualifications	3 (15.79%)
- GCSE's or equivalent	10 (52.63%)
- A-levels and above	3 (31.58%)
Race/Ethnicity	
-White	10 (52.65%)
-Asian/Asian British	2 (10.53%)
-Black/African/Caribbean/Black British	3 (15.79%)
-Mixed/Multiple ethnic groups	4 (21.05%)
Migration status	
-Born in the UK	17 (89.47%)
-First language English	17 (89.47%)
Relationship status	
-Married or Co-habiting	3 (15.79%)
- Single	16 (84.21%)
Children	
-Ever had children	14 (73.68%)
-Average number of children (n=14) (mean (sd)) [range]	2.5 (1.51) [1-5]
-Currently living with any children under 18yrs	5 (27.78%)
-Loss of custody of any children	5 (27.78%)
Accommodation type	
-Rented accommodation	16 (84.21%)
Refuge or other supported accommodation	3 (15.79%)
Employment	
-Paid or self-employment	2 (10.53%)
-Voluntary work/education/training	1 (5.26%)
-Unemployed or exempt through disability/health	14 (73.69%)
-Housewife	2 (10.53%)
Ever been homeless	12 (63.16%)
Ever been in prison	2 (10.53%)
Consider self as having a disability	3 (5.26%)

Table 11: Trauma, substance use, and mental health experiences of the study participants

Variable	n=19 Count (%) or Mean (SD) [range]
<b>Trauma history and symptoms</b>	
PTSD symptom severity (PCL-5) (mean (sd)) [range]	53.95 (13.78) [22-72]
Meets criteria for PTSD (PCL-5 >33) (n) (%)	18 (94.74%)
Received prior treatment for PTSD (n) (%)	2 (10.53%)
Lifetime exposure to stressful events on LSCR-R [1-33]	18.74 (4.48) [9-27]
Exposure to interpersonal violence in last 6 months	10 (52.63%)
- Frequency of interpersonal violence in last 6 months (n=10)	3.10 (2.59) [1-8]
Exposure to any other stressful events in the last 6 months	17 (89.47%)
-Frequency of any other stressful events in last 6 months (n=17)	2.88 (2.26) [1-9]
CPA (n=18*)	14 (77.78%)
CSA	14 (73.68%)
APA (n=18*)	17 (94.44%)
ASA	12 (63.16%)
Exposure to lifetime intimate partner abuse (CAS-SF) (yes/no)	19 (100%)
-forms of abuse (mean)	9.32 (3.76) [2-15]
Any abuse in past 12 months (yes/no)	7 (36.84%)
- Composite abuse scale score – past 12 months (n=7)	20.44 (11.17) [6-32]
Any abuse in past 1 month (yes/no)	5 (16.32%)
<b>Substance use</b>	
ASI Alcohol composite score	0.15 (0.23) [0-0.84]
ASI Drug composite score	0.11 (0.15) [0-0.38]
Years used alcohol to intoxication (n=18)	10.56 (11.18) [0-32]
Years used illicit drugs	15.32 (11.41) [0-32]
Prior treatment episodes	3.42 (3.86) [0-15]
<b>Any lifetime substance use</b>	
Alcohol	6 (31.58%)
Heroin or other opiates	10 (52.63%)
Cocaine (including crack)	12 (63.16%)
Cannabis	8 (57.89%)
Hallucinogens	4 (20.05%)
Sedatives	4 (20.05%)
Stimulants	3 (15.79%)
Polydrug use	14 (73.68%)
<b>Current treatment (most problematic substance)</b>	
Alcohol	4 (21.05%)
Heroin or other opiates	6 (32.58%)
Cocaine (including crack)	9 (47.37%)
Poly-substance (including alcohol)	11 (57.89%)
Abstinence in prior 30 days	11 (57.89%)
<b>Current medication for substance misuse</b> (Subutex/Methadone)	4 (21.05%)
<b>Mental Health</b>	
-Suicide attempt in the previous 6 months	2 (10.53%)
-Received a mental health diagnosis in their lifetime	16 (84.21%)
-Depression (PHQ-9) average score	16.58 (5.19) [3-24]
-Meets criteria for Depressive Disorder (PHQ>9)	18 (94.74%)
<b>Current mental health medication</b>	
-Anti-depressants	14 (77.78%)
-Other	3 (16.67%)

### 7.1.3.1 Substance use

Women reported lifetime problems with a variety of substances, most commonly heroin and other opiates or cocaine (including crack), and 74% reported at least one year of poly-substance use

where they used more than one substance a day. The mean number of years of reported illicit substance use was 15.32 (SD 11.41), with a range of 1- 32 years. The mean number of years of regular alcohol use to intoxication (more than 3 times a week) was 10.56 (SD 11.8). In terms of current treatment episode, 21% (n=4) reported treatment for alcohol use, most commonly in conjunction with other substances (16%, n=3), 33% (n=6) reported current problematic use relating to heroin or other opiates, and 47% (n=9) reported problems with cocaine (including crack). More commonly women were in treatment for poly-substance use (58%, n=11). Thirty-one percent of women (n=6) reported any illicit drug use in the past 30 days with a mean of 14 days of use in the past 30 (SD13.10) (range 2-30). Twenty-six percent of women (n=5) reported drinking to intoxication in the previous 30 days with an average of 13.4 days (SD13.58) (range 1-30). Fifty-eight percent (n=11) of women reported abstinence from any substances in the past 30 days.

Normative data do not exist for the ASI composite scores and in the literature, scores are highly variable across substance treatment populations (Becker et al. 2005). The ASI composite scores range from 0-1, with 1 indicating greater severity, and the composite score for the study sample at baseline was 0.15 (SD 0.23 (range 0-0.84) for alcohol use and 0.11 (SD0.15) (range 0-0.38) for illicit drug use. Forty seven percent of women scored zero for alcohol and 53% scored zero for drugs. It should also be noted that of the 58% (n=11) women reporting abstinence in the past 30 days, some were only recently abstinent; and some women had been abstinent for several years. The impact of active substance use on group dynamics is discussed further in section 7.1.5.

#### **7.1.3.2 Lifetime history of trauma and other stressful events**

Women reported an average of 18.74 out of 33 (SD 4.48) (range 9-27) forms of stressful events experienced during their lifetime, as measured by the WCDV Life Stressor Checklist-Revised (LSC-R). These events included the unexpected death of someone close (84%, n=16), serious money problems (79%, n=15), and witnessing physical violence between parents (74%, n=14), Reported rates of exposure to IPA were high, as to be expected due to the inclusion criteria.



Seventy-eight percent<sup>39</sup> of women (n=14) reported childhood physical abuse (CPA) and 74% (n=14) reported childhood sexual abuse (CSA). Any physical abuse in adulthood (APA) was reported by 94% of women (n=17) and sexual abuse (ASA) by 63% of women (n=12). Women reported stalking and threats to kill or serious harm (84%, n=16), rape (68%, n=13), 37% of women (n=6) reported sex in exchange for money, drugs or other goods, and 21% (n=4), participation in prostitution. All women reported lifetime history of emotional abuse and lifetime history of intimate partner violence with an average of 9.32 (SD 3.76) (range 2-15) of the 15 items of abuse covered by the Composite Abuse Scale-Short Form (CAS-SF).

#### **7.1.3.3 Recent exposure to IPA**

Just over half of women reported any form of exposure to IPA in the previous six months. Of those women experiencing IPA, they reported an average of 3.10 (SD 2.59) out of 9 forms of abuse (range 1-8). Women were asked about intimate partner violence in the past 12 months and the previous month with 37% (n=7) and 16% (n=5) responding positively to any of the items respectively.

#### **7.1.3.4 Co-occurring mental health conditions**

The majority of participants (84%, n=16) self-reported that they had received a diagnosis from mental health services, most commonly depression (58%, n=11) with another co-occurring problem such as anxiety (32%, n=6). Other diagnoses included Borderline Personality Disorder (11%, n=2), Complex PTSD (11% n=2), Psychosis (5%, n=1), Bipolar (5%, n=1) and Attention Deficit Hyperactivity Disorder (5%, n=1). Fourteen women reported receiving any form of psychosocial intervention for mental health problems in the past. Most women (95%, n=18) scored above the threshold for a probable depressive disorder according to the PHQ-9 ( $\geq 10$ ). The average score of 16.58 is suggestive of moderately severe depression (Kroenke et al., 2001)

---

<sup>39</sup> Based on data for 18 women

#### 7.1.4 Study retention

The study protocol aimed to originally recruit 24 women into the study. Figure 14 provides a CONSORT flowchart of study participants. The numbers include two women who were screened for eligibility and took part in baseline assessments twice because they withdrew from the first group and subsequently enrolled in the second group, requiring a repeat of the screening and baseline interview. A total of 30 distinct women were assessed for eligibility (reported as n=32), and 21 were eligible to take part in the study (reported as n=23) and went on to complete the baseline assessments within the pre-determined two-week window for consent and baseline, following screening. Two women, both friends, subsequently withdrew from the study after the baseline interview. Of these two women, one woman had a daughter who was on a social work placement at the study treatment service during the study and the staff could not assure confidentiality. The other woman then subsequently withdrew from the study because her friend was no longer taking part.

Twelve women started the first group, of which two dropped out in the first few weeks of the group; one after the first session because she missed group pre-orientation and as a result struggled with the first session and clashed with the facilitators when they tried to apply some boundaries in the group, as she reflects in this quote:

“Me and [Facilitator 2] didn’t get off to a good start I think her way of working and my way of expecting to work in a group was a bit different...” (Steph, Group 2, 9-sessions, PTSD improvement at T2 & T3)

A second woman only attended the first session and was banned from the service for using drugs on the premises. Although she was allowed to continue attending Seeking Safety, she did not wish to. Following conversations with myself, both women then requested to remain in the study and join Group 2. Therefore, baseline data were repeated and follow-up data pertains to their involvement in the second group cycle.

Eight women started Group 2 (including the two women who had begun but dropped out of Group 1) and were retained in the study, bringing a total of 19 individual women whose data were

included in the intention to treat analysis. Of these, 18 (95%) completed T2 (post-intervention) interviews and 16 (84%) completed T3 (3-months post-intervention) interviews.

#### **7.1.4.1 Study attrition**

One participant was lost to follow-up at T2 (post-intervention), and three at T3 (3-months post-intervention). Two of the study participants were experiencing family-related issues which may have influenced their desire to prioritise interviews. One participant was in early stages of pregnancy at T3 and despite three scheduled interviews at her house, all were cancelled at the last minute. A second participant had changed her telephone number at T3 and could not be contacted directly or through her nominated safe contact (a key-worker). I subsequently heard through a key-worker that she had lost custody of her baby. This same participant was accompanied to the T2 interview by staff from the mother and baby unit, and only had 45 minutes to complete the interview before leaving to feed her child, resulting in an unfinished interview and missing data. Attempts to follow up by phone to complete the interview were unsuccessful.

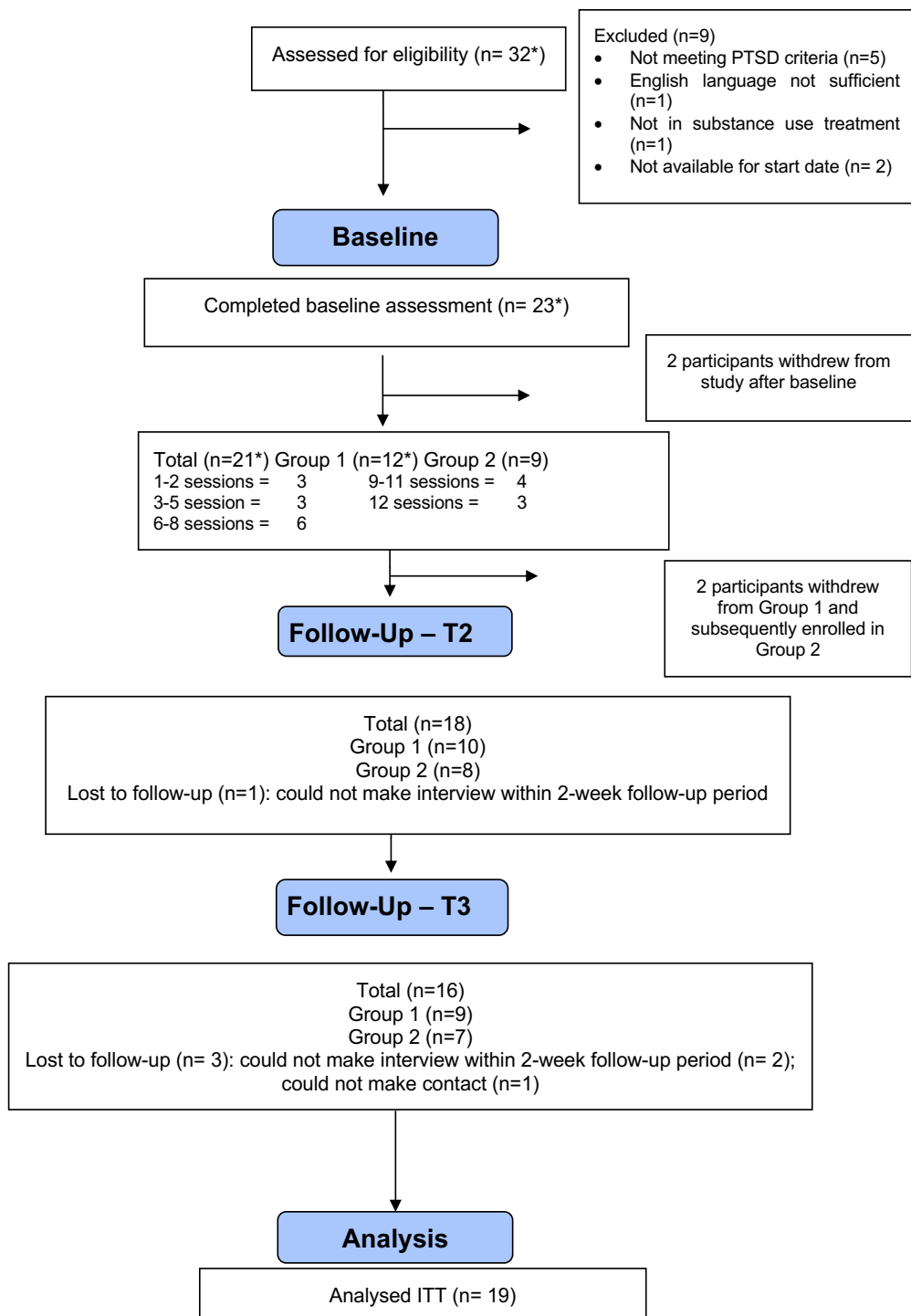


Figure 14: CONSORT flowchart of study participants

### 7.1.5 Group retention

Sixteen of the nineteen women who started the group, attended the pre-orientation group session which was held a week prior to the start of the group. Four women from Group 1 did not attend the pre-orientation, and two of these reported struggling with the group dynamic in the first session (see qualitative data below), and subsequently did not attend any further sessions. Whilst they were provided with the hand-outs from the pre-orientation session, they did not receive a comfort-kit.<sup>40</sup> Therefore, attendance at the initial pre-orientation group session was made a pre-requisite for starting the second group and this resulted in attendance by eight of the nine women enrolled in Group 2. The ninth woman was unable to attend due to ill health and the group gave permission for her to start the group the following week. The study design deemed attendance at any six sessions (50%) (not including pre-orientation) as minimal dose exposure. The CONSORT flowchart outlines the number of sessions attended by participants: all participants completed at least one session (not including pre-orientation), over half (n=13, 68.4%) completed at least six sessions, and three (16%) completed all 12-sessions, with an average of 7.2 (SD 3.7) of sessions completed. The service manager of the study treatment service viewed the retention rates for the group as a definition of group success and explained why:

“Well the [former] women’s programme we couldn’t retain anyone for longer than 2-3 sessions you know, the retention rates were quite good on both Seeking Safety groups.....” (Service Manager)

#### 7.1.5.1 Missed sessions

In the qualitative interviews, women gave various explanations for why they missed sessions or dropped out of the group completely. These were categorised into the interpretive themes of: 1) *competing priorities*, 2) *emotional intensity*, and 3) *relapse*.

---

<sup>40</sup> At the pre-orientation sessions, women were provided with materials to make their own ‘comfort kit’ bag representing the five different senses for use as a grounding tool throughout the group.

#### *7.1.5.1.1 Competing priorities*

Amongst those completing six session or more, reasons for missed sessions were due to competing priorities such as doctors' appointments, lack of childcare in school holidays, visiting family, and sickness. One woman who attended only three sessions explained she was consumed by a court case involving her daughter who was in jail due to drug possession and who was at risk of losing the family home. She stated that there was nothing anyone could have done to help her attend more sessions because her mind '*was fixed on one thing and one thing only.*'

#### *7.1.5.1.2 Emotional intensity of the group and relapse*

For women who attended less than six sessions, the overwhelming reason given was due to substance use and/or the strong emotions evoked by participating in the group. One woman who attended only one session and had missed the group pre-orientation described feeling 'stupid' and 'isolated' from the group. These emotions were then compounded with more emotional pain from triggered memories listening to others talking about children. She said it had been 24 years since she has seen her children who had all been removed from her care. For another woman, it was the combination of both reasons which caused her to miss multiple sessions. She had been asked to leave the Abstinence programme because of a 'slip up' in drinking which resulted in her feeling rejected and very emotional. At the same time she described attending a Seeking Safety session and having a flashback that she was not able to express in the group and left her feeling very vulnerable. She opted to take a week out to do another course offered by a different service, because she perceived it would better support her relapse.

"That's why I went to do this other thing... I thought my priority was to stay sober, so I had to have a choice then, do I come into here or do I do this [other] course for a week...cause I just didn't know if would come here the next time, come out and pick up a bottle of vodka."  
(FG\_Rachel, Group 1, 3-sessions, PTSD improvement T2 & T3)

Another woman who dropped out of the first group and then re-enrolled into the second group with poor attendance said there was nothing that anyone could have done to help her attend more sessions and expressed a sense of hopelessness.

“No no. I give up. I did, I kind of give up. If I am going to do this I am going to do this on my own maybe. I have been trying for years, I’m 50 now.” (Ali, Group 2, 4-sessions, PTSD improvement at T3)

#### **7.1.5.2 The impact of substance use on group retention**

It is noteworthy that half of the women (n=3) who attended less than six sessions also had baseline ASI-Drug composite scores falling in the 75<sup>th</sup> percentile i.e. had more active substance use compared to the majority of the participants. The inconsistent attendance by those more active in substance use was identified in the narratives of some participants and the group facilitators:

“If someone has been using and drinking they can’t do that, and she [intervention author] thinks they can, that is not possible... people who were using, you could see they didn’t come.” (Facilitator 1)

“It was different from session to session I would say, um but that is because I think different people coming in and out I guess, and some people kind of being you know, not as consistent I guess. And it was difficult sometimes...” (Gina, Group 2, 8-sessions, PTSD improvement at T2)

#### **7.1.6 Suitability and acceptability of the study measures**

Women’s experiences of undertaking the structured interviews across the three time-points varied. Descriptive statements ranged from ‘fine’ and a ‘positive experience’ to contrasting views of ‘distressing’, with some women exploring how their views on completing the questionnaires changed over time. Following qualitative analysis of this data, three interpretive themes were identified: 1) *an opportunity for reflection*, 2) *distress*, and 3) *relevance and clarity of questionnaires*.

##### **7.1.6.1 Opportunity for reflection**

For women who found the experience of answering the structured questionnaires a positive one, they described the process as giving them ‘food for thought’:

“It made me really think all the questions you were asking. I thought ‘oh my god I have all of them, done all that’ you know. ‘I’ve got PTSD’...I thought I suppose I have been a bit like that forever, but maybe it only started when I was four and when various traumas started.” (FG\_Chriissy, Group 2, 9-sessions, no PTSD improvement)

For some, the longitudinal nature of the assessment process provided an opportunity to reflect on progress. Women stated they had gained confidence, or were in a better place at the follow-up interviews, because the questionnaires either felt more manageable or they thought they were answering more positively to items. This view was expressed predominantly among those experiencing PTSD improvements at either of the time-points:

"I felt fine doing them actually yeah. I feel a lot more confident as well since Seeking Safety group and doing the questionnaires as well." (Jamila, Group 1, 7-sessions, PTSD improvement T2 & T3)

"What I found is that every time I've done it [questionnaires], I've got stronger you know what I mean ... I felt more confident in the answers you know than first time around I suppose from doing the group." (Steph, Group 2, 9-sessions, PTSD improvement T2 & T3)

#### **7.1.6.2 Distress**

The distress experienced by participants during the structured interview was also varied. Some women stated that the repeated questions about IPA were upsetting and made them feel down or brought back painful memories. This experience was shared amongst women who did and did not show improvement in PTSD at either of the follow up time-points:

"I suppose it makes you feel a bit down really cause there are so many questions on top of the other you know so... and some bits are a bit hard to answer." (Mariella, Group 2, 2-sessions, PTSD improvement T2&T3)

"...putting it down on paper, it really does bring it home sometimes, which of course causes distress... I was just glad that I can contribute really and doing something positive." (Sophie, Group 1, 11-sessions, no PTSD improvement)

However, none of the women interviewed needed to seek any support from the study treatment staff afterwards, which was always offered following the end of the interview, and although the question was not asked specifically, some women stated they did not feel the need to go and use substances as a result of taking part.



#### **7.1.6.3 Relevance and clarity of the structured questionnaires**

In response to questions about the relevance of the structured questionnaires, women were in general agreement that they were relevant and that the coping skills were reflective of topics covered in the sessions. If any specific comments were given, these related to the importance of capturing 'depression' or 'general mood'. In terms of the clarity of questionnaires, I asked women to feedback on the language and their understanding of the questions; women said these evoked mixed responses. Whilst some felt they were acceptable, other women stated they found certain questions complicated or confusing, but for the most part could not remember exactly which questionnaires or provide further clarification on which items. Some women reflected that the questions were difficult to answer because of their changeable mood. One woman who struggled with the trauma cognitions questionnaire explained:

"I have a good day and a bad day...if am feeling bad I might feel negative about myself but on a good day, yeah I wouldn't so it was hard to answer some of them, a bit in between." (Jasmine, Group 2, 12-sessions, No PTSD improvement)

#### **7.1.6.4 Researcher field-notes: clarity of measures**

My field-notes recorded at baseline and follow-up interviews shed more light on the acceptability of measures. Some women found the Social Provisions Scale (SPS) particularly difficult. This scale involves 24 questions involving different elements of social support, both positive and negative elements, and was administered towards the end of the interview. Two participants told me they found the mixture of positively and negatively worded questions extremely confusing, especially after the emotion evoked by the previous questionnaires.

For some the question on the Coping Skills Questionnaire (CSQ) that asked about avoiding or getting out of a relationship evoked confusion. Some said they answered 'Extremely' because they were not in a relationship and some answered "Not at all" because they were not in a relationship. This highlights the need for the interviewer to clarify with participants the aim of the question to ensure respondent consistency. Other field-notes highlighted potential disparities in the way some women answered the ASI- drug and alcohol questions related to perceived problems in the past 30 days and perceived need for treatment related to these problems. Someone's recognition of the need for treatment could actually be an important sign of recovery

but would also increase someone's ASI score, interpreted as having worsened over time. These issues reiterate the importance of the questionnaire administrator being clear and consistent on how these ASI items should be scored and providing clarification with participants.

I also noted potential feasibility issues related to the CAS-SF in terms of accurately capturing the full extent of intimate partner violence by the women in the study. This is related to how women defined an intimate partner. There were at least two occasions where women stated they were not in an intimate relationship, however they also reported recent abuse (ranging from emotional to sexual and physical abuse) from a man who was staying with them at their flat regularly. This reiterates the importance of administering an alternative IPA questionnaire at repeated time points, such as the WCDV LSC-R used in this study.

The next section moves on to describing the perceptions of the group facilitators and service manager of the study treatment service.

## **7.2 Implementation of Seeking Safety: staff perceptions**

This section comprises predominantly qualitative data, interview and researcher field-notes, in order to illustrate the facilitator experiences of reviewing and adapting the Seeking Safety intervention and preparation for group delivery, as well as their experience of undertaking assessment of adherence to the fidelity of the intervention ("fidelity monitoring").

### **7.2.1 Pre-implementation**

Chapter 5 outlined the process of review and adaptation of the Seeking Safety intervention in preparation for implementation. The group facilitators were asked about their experience of taking part in this process. Their overarching view was not very positive, experiencing it as resource intensive, and leaving inadequate preparation time for group delivery. The main interpretive themes from the analysis of the interviews were as follows: 1) *resource intensive*, 2) *lack of preparation time*, and 3) *inadequate training*.

### **7.2.1.1 Resource intensive**

The facilitators found the reading and preparation required to choose the topics and adapt hand-out material too demanding, and as such they felt they were not able to do it in a fully informed manner:

“It felt tedious at times, very tedious going through and I suppose it is kind of quite complex and the material is quite dense and I wasn’t always sure what we were doing and what our intention was.... and again when we talk about this, for the business of my schedule I didn’t always to have the time to fit in, meetings was one thing, that was ok, but that additional reading...”  
(Facilitator 2)

Both facilitators wanted to be engaged with the ‘end process’ as they called it and would have preferred that someone else made the decisions about topics and the material review. The other facilitator felt this process distracted from preparing for the intervention delivery:

“We had all those meetings... I was not quite clear how we were going to deliver it and I remember saying to you I need to know because I have to prepare myself.... when you start the topics and programme that is different but to get there.” (Facilitator 1)

Her priority lay with reading and absorbing the preparation material (from the manual) but she found this overwhelming, as illustrated by this quote:

“I really did read the chapter before with the introductions and give some ideas about each topic and its quite a lot to get into your head...but to deliver everything, plus what she [intervention author] says about every topic, she gives some ideas of what you need to look at, what the rationale is, it’s quite confusing, I didn’t get it, I was quite scared.” (Facilitator 1)

### **7.2.1.2 Lack of preparation time**

More preparation time was required to plan for delivery of each intervention session. Although not mentioned by the facilitators, the service manager also stated that more preparation time was needed once the group commenced:

“I think the one thing probably could have happened a little bit more is for [facilitator names] to have more time together at least for the first run through, cause they literally had an hour before they started delivering each week and although they went off and had clinical supervision

together and then they would debrief after the session, I think um, if it was somebody else who didn't have the skills that they have, they would have got in a fluster.” (Service Manager)

The manager went on to suggest that a full day of preparation was needed to deliver one weekly two-hour session.

### **7.2.1.3 Inadequate facilitator training**

The two group facilitators received a one-day training using Seeking Safety online training videos, facilitated by myself, as outlined in Chapter 5, section 5.4. The feeling of confusion and anxiety felt by the facilitators pre-group may have been exacerbated because this training did not commence until August 2017, with the first session delivered in October. Moreover, the facilitators expressed views that the training was inadequate. Their concerns centred around the lack of fit between the type of groups they saw enacted out in the videos and the group dynamic that played out in the study. They felt the women in this study did not respond neatly to the requirements to limit their check-in, as explained by one facilitator:

“I think the video for me it was not quite real, for the women it did not show me the reality of the groups...so in the video when she says, you ask something, they answer back and then we say hold that and we will talk later on... We can't relate to what she [intervention author] does and what we have...” (Facilitator 1)

## **7.2.2 Fidelity monitoring process**

### **7.2.2.1 Group 1**

The first group began in October 2017 and the fidelity monitoring process was conducted solely by myself, following some initial online training (as outlined in Chapter 5, section 5.4). Group one served as a practice round to support facilitators to deliver the group with adequate adherence to fidelity, and therefore scores were not administered, on the advice of the intervention author, Lisa Najavits. I watched each video-recorded session the next day and completed the qualitative component of the Seeking Safety Adherence Scale (Najavits, 2003) (Appendix 16). The original intention was to provide the feedback in a face-to-face discussion weekly, however in practice this was not always possible because of the time pressures on both facilitators. Therefore, at the

end of week two, a joint decision was made to provide the feedback in written form. Thereafter, a written feedback sheet was emailed to facilitators following each session, which included suggested modifications with suggestions of the manual sections to re-read.

Key areas for feedback to the facilitators after Group 1 centred on better time keeping during check-in; managing disclosures of trauma or unsafe behaviours; and including more 'rehearsal' elements where appropriate, a key behaviour change technique (BCT) (see Chapter 5, section 5.3). For example, participants should be encouraged to discuss with the group the coping skills they could resort to when faced with the next triggering situation.

My field-notes included reflections after the first session about the emotionality and vulnerability of the group and the importance of maintaining a balance of women in different stages of recovery and levels of stability. I also noted a certain level of anxiety felt by the facilitators after certain sessions; in the breaks they described themselves as feeling ungrounded, unsettled, and found the group dynamic challenging. This was particularly apparent when there was a larger group, and/or when certain women were present. Some topics lent themselves to BCTs such as 'role-play' or 'reframing out-loud' but the facilitators found incorporating these difficult. In week three, I noted that some of the facilitator anxieties may be due to the pressure they are feeling to adhere to all the elements of adherence covered in the fidelity monitoring and responding to written feedback. However, I also noted how the two facilitators were bonding and supporting each other in the delivery of the material, which was encouraging.

#### **7.2.2.2 Consultation with the Seeking Safety intervention author**

Following the end of the first group, these key concerns were discussed with Lisa Najavits,, in a phone call discussion. She suggested that the study treatment service offered a process group during the week to respond to issues with women wishing to talk more about general problems, in order to allow the Seeking Safety group sessions to focus on coping skills. She provided several suggestions for phrasing and 'stock' responses to help facilitators move people away from talking about the past. In terms of responding to trauma discussions, she stressed the approach of validation, rationale and case management: validating feelings, providing a rationale as to why

talking about trauma is not safe in the group, and offering case management as a follow-up. She also suggested providing opportunity for the facilitators to rehearse the key phrases, and to practice the role-play elements with me or a non-research group. Lisa advised that I should ask the facilitators to suspend judgement about what works and learn from the clients. Finally, an agreement was made with the author, that if there were continued challenges with fidelity during the second group, I could send a video-recorded session to her for advice.

### **7.2.2.3 Adaptions agreed for Group 2**

Unfortunately, a scheduled training session due to run in December 2017 was cancelled due to competing priorities faced by one of the facilitators. Instead, a face-to-face meeting was held with the facilitators to talk through some of the feedback identified during the fidelity monitoring process and suggestions stemming from my conversation with Lisa Najavits. Due to time constraints neither facilitator was able to commit additional time for rehearsal practice before the start of the next group cycle in January 2018. However, as a result of these discussions, it was agreed the following points would be raised with participants at the pre-orientation group session to:

- emphasise how the Seeking Safety group may differ to others they have attended – particularly the structured format;
- emphasise that the group does not facilitate the detailed discussion of trauma and why it may be unsafe to do that in group setting;
- emphasise the structured nature of the check-in and how the facilitators will encourage women to keep to their allocated 2-3 minutes, in order to provide sufficient time to discuss the topic;
- stress the offer of one-to-one support if women feel they need to talk more, and to remind people of the women's process group available on Monday afternoons.

Due to the challenges of managing the group-dynamic (section 7.3.2), the facilitators also requested a maximum of 10 women were recruited for Group 2, which was observed. This meant the original recruitment target of 24 women was reduced to 22. Based on feedback from the initial focus group (section 7.4), combined with that of the facilitators, it was also agreed to trial one

topic over two sessions; the topic of Anger was chosen, again based on participant feedback (section 7.3.1).

#### 7.2.2.4 Group 2

The full Seeking Safety Adherence Scale (Appendix 16) was used to monitor adherence to intervention fidelity during Group 2. The scale consists of three sections: format (4 items); content (8 items); and process (8 items), with each item scored for adherence (quantity) and helpfulness (quality) except for process items which have one score to cover both. Scores range from 0 (low) to 3 (high) with 0.5 increments allowed. The Scale also provides space to list positive and negative descriptions for each item. The mean scores for each section items are outlined in Table 12. Feedback from myself to the facilitators continued to be provided in written form.

Table 12: Scoring of the Seeking Safety Adherence Scale for Group 2

Format (4 items)		Content (8 items)		Process (8 items)
Adherence	Helpfulness	Adherence	Helpfulness	Overall
2.26	2.18	2.02	2.19	2.43
<b>Areas for improvement</b>				
Managing disclosures of unsafe behaviour and trauma.		Introducing the practice and rehearsal elements of the group content.		Managing the dynamic of group members who felt 'cut off' when they were encouraged to focus on coping skills.

Because there were continued problems with perceived adherence to fidelity during the second group, a modification request was approved by the KCL PNM Ethics Sub-Committee on the 15<sup>th</sup> February 2018 in order to send an audio-recorded session to Lisa Najavits. One audio-recording was sent, representing a session I had scored the lowest. Lisa indicated that the scores I had given this session were too high. However, by this stage, the group was nearing completion, and there were limited options for addressing the challenges with the fidelity monitoring process, in terms of my ratings, and coaching the study facilitators.

#### **7.2.2.5 Facilitator experiences of the fidelity monitoring**

In the qualitative interviews, facilitators expressed a negative experience of the fidelity monitoring process, confirming some of the reflections and concerns in my field-notes. Qualitative analysis of the interview data identified three key themes: 1) *unexpected roles imposed on facilitators*, 2) *ineffective feedback mechanisms*, and 3) *incongruence of fidelity requirements with group realities*.

##### *7.2.2.5.1 Unexpected roles imposed on facilitators*

Despite the reason for fidelity monitoring being explained prior to training, and copies provided to them of the Adherence Scale, both facilitators expressed surprise that the fidelity monitoring process ultimately ended up being an ‘evaluation of their performance:’

“I didn’t know it was going to be about us. I thought it was about the clients. I was nervous about that, with cameras and being recorded, but I thought it was just about the clients. When I thought it was about us I nearly had a heart attack.” (Facilitator 1)

“So I didn’t know it was going to be an evaluation of our performance, even though you were saying it was about the fidelity, at the end of it, you are giving us feedback on our interventions so it is about what we are doing and what we are not doing.” (Facilitator 2)

##### *7.2.2.5.2 Requirements of intervention adherence incongruent with group realities*

This unhappiness was fuelled by the content of feedback provided weekly. It was experienced as a ‘benchmark and level of analysis that was happening outside of the environment’ which was incongruent with the realities of the group. One facilitator stated that the encouragement to do things differently in check-in, or try out more rehearsal, did not take into account the tensions they were facing about having to hold a safe therapeutic space:

“...As two facilitators we came almost from the same place as to how we would be running those spaces, but we have this third tangent. And I didn’t always feel that you were thinking about what was happening here and what our responsibility was as therapists and responding to what individual members needed from us.” (Facilitator 2)

The other facilitator expressed views that suggested that the requirements of adherence to intervention fidelity were incompatible with running a diverse and eclectic group in terms of support needs:



“But it is quite difficult when you had different people in the group, and behaved the way they behaved, because I think it is like trying to fit something in that doesn’t fit. What you were asking was something that we cannot do in the group, it was not because of us I don’t think, its not that we were not managing it.” (Facilitator 1)

One facilitator cited a specific component of the fidelity assessment that requires an 80:20 balance of discussion in favour of the participants. Interestingly, this was never a component identified in my feedback as requiring attention:

“...to be very mindful of 20% intervention [facilitators talking for 20% of time] meant that it was like it was held at this very superficial level but with such deep and powerful themes. That for me was, there was a irresponsibility about it, it felt really irresponsible sometimes and that felt incredibly difficult actually, incredibly difficult.” (Facilitator 2)

Both facilitators described feeling anxious about balancing all the competing elements of the treatment protocol, reflecting comments in my fieldnotes discussed earlier:

“You invite women to be very open and go into very deep places in limited time. I felt as though we were dangling on a cliff edge like inching along with this possibility of this and saying to them don’t look down...I have cried, really about this work, oh my god, I feel really as though I am being dangerous with them....” (Facilitator 1)

#### 7.2.2.5.3 *Ineffective feedback mechanisms*

Both facilitators expressed discontent with the feedback mechanisms suggesting the written feedback was unsuitable. They suggested that more dialogue was needed and that review sessions should have been scheduled in advance, in order to review feedback. As outlined in section 7.2.2.1 above, attempts were made to introduce other ways of providing feedback and coaching; and both facilitators did acknowledge the time constraints they faced particularly in terms of their availability after the sessions for the debrief. Clinical supervision was left to the study practitioners to organise with funding available for fortnightly sessions. However, the supervisor was not familiar with Seeking Safety and the study practitioners believed they would have been more useful if I attended. The quote below alludes to why:

“There was a point for us in debriefing and understanding what was happening, but actually we are all part of a research project so I think it would have been also useful for you to hear what our supervisor was saying... and also just for us to process things you know we never had a chance to really debrief or review what we are doing or then sit together with you.” (Facilitator 2)

The facilitators' experience of being monitored and assessed dampened their enthusiasm for the intervention model, highlighting the key role that the fidelity monitoring process can play in facilitator perceptions of treatment acceptability and feasibility. Their views (positive and negative) on more specific elements of the intervention have been integrated into the views of the group participants that are discussed next. Figure 15 below provides an illustrative summary of the key findings influencing the acceptability of the intervention for the participants.

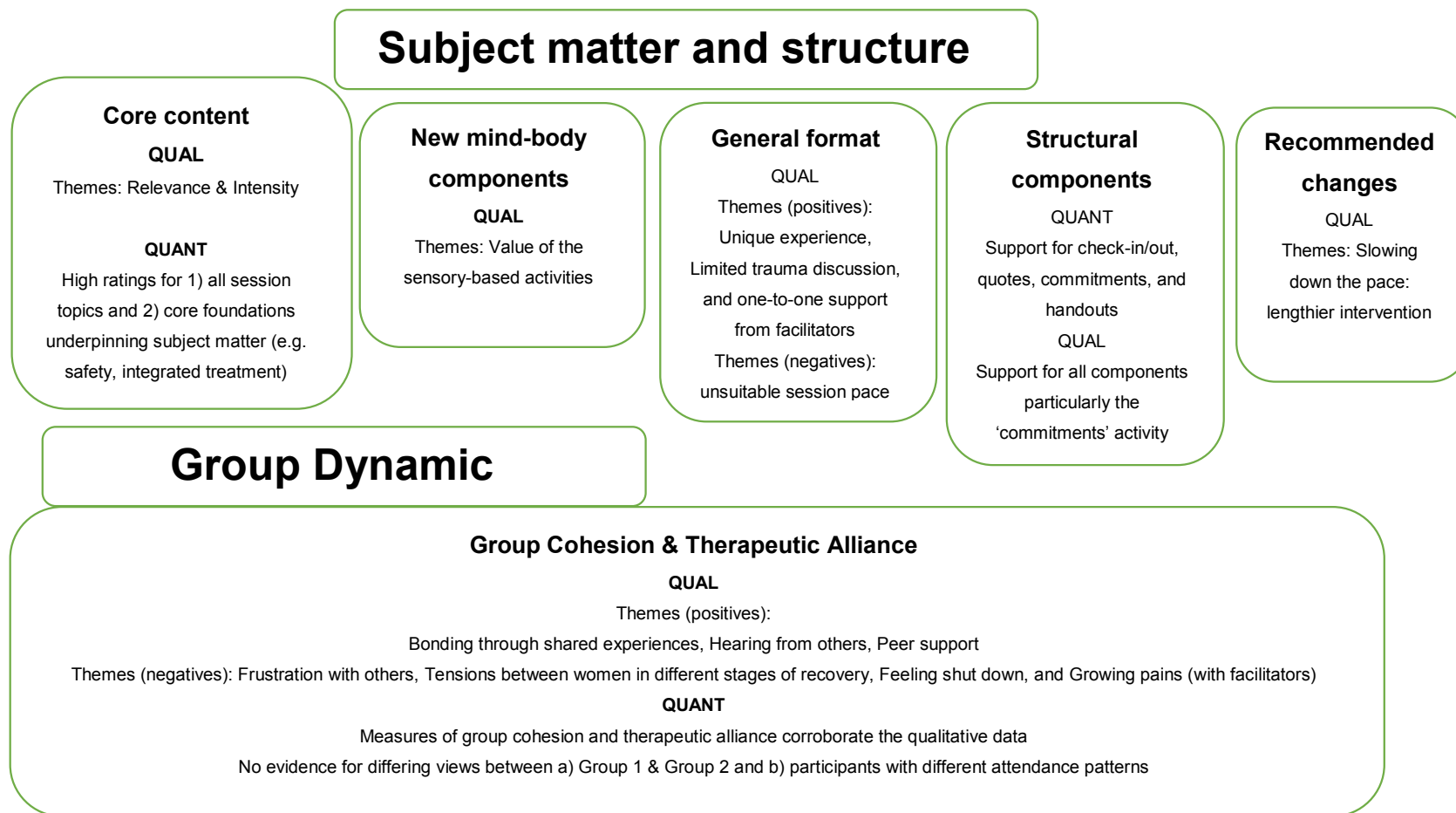


Figure 15: Map of key findings relating to acceptability of Seeking Safety

## 7.3 Subject matter

### 7.3.1 Core content

Acceptability of the subject matter forming the main content of Seeking Safety was collected using session feedback forms, completed at the end of each session, and semi-structured interviews. However, the qualitative interviews were most informative, providing a richer and more nuanced explanation of how women experienced the topic content. Analysis of women's views comprised two main interpretive themes: 1) *intensity* and 2) *relevance*. Facilitator views further corroborate the relevance of the content.

#### 7.3.1.1 Intensity

Women described the topics and content of the intervention as 'intense' with some describing the group as 'hard' or 'difficult' at times:

KB: and how was it different to other groups you have been in?

Steph: it was, because it was more, it was more intense..." (Steph, Group 2, 9-sessions, PTSD improvement T2 & T3)

"At least every topic in the whole thing, everyone had something that really hit them quite hard." (Sophie, Group 1, 11-sessions, PTSD improvement T2 & T3)

However, among women with better attendance, this intensity was viewed as a positive aspect, contributing to the overall positive experience of the group, in comparison to other groups offered by the study treatment service. Chrissy's quote reflects the sentiment well:

"Everyone cried you know they really did and that is something that you don't often, people are not very brave in these groups they are just something to do and they actually don't necessarily work. The Stabilisation [group], really doesn't work." (Chrissy, Group 2, 9-sessions, No PTSD improvement)

### 7.3.1.2 Relevance of session topics to women's lives

There was also enthusiastic praise for the topics as being relevant to women's lives. This came primarily from women who experienced clinically meaningful PTSD improvements at either of the follow-up time-points. The consistent focus on trauma and PTSD was valued:

"Yeah, and I am just glad that people, someone is paying attention a bit more to what we have been going through and sometimes you can suffer from PTSD and not know it, you know, and you think what the fuck is wrong with you, why can I not function at all." (Mariella, Group 2, 2-sessions, PTSD change T2 & T3)

Some of the same women who described the intervention as intense and difficult were also the ones praising the variety and relevance of topics and appreciated the different activities and exercises involved:

"There wasn't one thing that was brought up and I thought that doesn't really relate to me...it was like no I can relate to each thing and each coping mechanism." (Rachel, Group 1, 3-sessions, PTSD improvement at T2 & T3)

"Yeah so if you feel you can relate to it, that if you feel comfortable where you are, and that you are gaining something from it, you will keep coming, you will." (Clare, Group 1, 8-sessions, PTSD improvement T2 & T3)

Interestingly, in both the focus groups, the topic of *Anger* was the one mentioned when asked about the helpfulness of topics. This excerpt is taken from the focus group following the end of Group 2:

FG\_Chriissy: I think for me the Anger one was really a good session, we could have done more.

KB: cause you had two sessions on that didn't you?

FG\_Chriissy: yeah but I mean we could have done 4, cause you know PTSD is anger, isn't it?" (Chriissy, Group 2, 9-sessions, no PTSD improvement)

This topic was also highlighted as important by one of the facilitators:

"Anger is a big thing for both disorders and so we need to really spend time on that, that is where, in my experience in substance abuse, where you are struggling most." (Facilitator 1)

In the semi-structured interviews conducted 3-months post-intervention (T3), the exercises taught in the *Grounding* topic were most frequently mentioned by participants in both groups:

"None of the topics were not unhelpful...the grounding is really then one that stuck in my head, that helped me immensely." (Clare, Group 1, 8-sessions, PTSD improvement T2 & T3)

"..the grounding was good, that little sort of questions that she asked us, you know the things she said." (Chrissy, Group 2, 9-sessions, no PTSD improvement)

"KB: which ones did you feel like were most useful for you?

Gina: Um oh goodness, I think the grounding, I really enjoyed that exercise." (Gina, Group 2, 8-sessions, PTSD change T2)

Despite misgivings expressed about the fidelity monitoring process, the facilitators were also supportive of the intervention, perceiving its utility. This reflected the reality that there is limited integrated group-work to address the co-occurring issues of PTSD and substance use within most substance use treatment services in England.

"To be honest with you I think this group-work, I think it would be very useful for the clients, a really good thing, cause we haven't got anything like this." (Facilitator 1)

"I do think it is an incredibly and powerful journey in which you can engage. I feel conflicted a bit because I think there is all of those negative things but also there is also something that is quite magical and that works about the programme, you know and its not far off of the place that I would want it to be." (Facilitator 2)

Some of the comments suggested that for some participants, the group was not as relevant for substance use:

"KB: Do you feel like since doing the group you have experienced any changes, I guess in terms of substance use, or psychological wellbeing?

Sophie: Substance use is more of my other groups...."

(Sophie, Group 1, 11-sessions, PTSD improvement T2 & T3)

“I’ve gone through the trauma side of things, and Rachel has gone for the substance side of things in helping with keeping safe and safeguarding yourself.” (FG\_Jamila, Group 1, 7-sessions, PTSD improvement T2 & T3)

### 7.3.1.3 Session feedback questionnaires

All the topics delivered in the sessions were rated highly according to the End of Session Questionnaires completed immediately at the end of each session; out of a maximum score of 3, the mean score for each topic ranged from 2.67-3.00. However, the topics identified in the qualitative interviews relating to *Anger* and *Grounding* were not the ones rated the highest. Chapter 5, section 5.2.3.4 outlines the 12 topics delivered as part of the intervention. The five mostly highly rated topics were: *PTSD*, *Creating Meaning*, *Recovery Thinking* (all cognitive topics); *Honesty* (interpersonal topic); and *Self-Nurturing* (behavioural topic).

The Seeking Safety Feedback Questionnaire, administered in the final session of each group cycle, asked to rate different aspects of the intervention on a Likert scale from -3 (greatly harmful) to +3 (greatly helpful). As displayed in Table 13 below, high ratings were giving to some of the core foundations underpinning the subject matter. As these questionnaires were completed at the final session, they will be biased towards those women attending more frequently.

Table 13: participant ratings of core foundations of the Seeking Safety intervention\*

Safety as the priority of treatment	Integrated treatment	Focus on abstinence	Focus on ideals	Focus on coping skills
3.00	2.75	2.52	2.63	2.83

\* Based on 14 questionnaires completed at the final session

## 7.3.2 The new ‘mind-body’ components

### 7.3.2.1 Value of the sensory-based activities

The qualitative data also identified that the new content introduced as part of the Seeking Safety adaptation, the ending ritual involving a fragrant spray placed onto the hands of each participant at the end of each session, and the compilation of the sensory ‘comfort’ kits for individuals to take-away, were highly valued by both participants and facilitators:

“...you know it was to do with emotional stuff as well as practical stuff but also the whole, you know, the cleansing at the end you know, even when we did that walking up and down and the fact that it was very not text book.” (Tara, Group 1, 12-sessions, PTSD improvement T2 & T3)

“Yeah that’s all good I like all those mixtures of therapy and complimentary therapy whatever. I think you had to put all sorts of techniques together, and not only one thing is going to work but yeah, that is something for me that is, I do really need smells, like whatever, face cream or shampoo (Chrissy, Group 2, 9-sessions, no PTSD improvement)

The comfort kit was mentioned on frequent occasions in response to questions about helpful aspects of the intervention:

“I have still got them smelly little bags as well that we made, yeah still got them, so that comes in useful sometimes, the smells... to help you comfort you, you know to get you out of that bad headspace and bring you into something a bit more loving and stuff.” (Steph, Group 1, 9-sessions, PTSD improvement T2 & T3)

This sensory aspect was also remembered by those with low attendance and tended to be the one thing they remembered most, and in some cases were still benefitting from. The participant quoted below dropped out of the group after one session and couldn’t remember much from the course apart from this:

“We had to pick up a little bag each to pick out things that are safe, when we need to bring ourselves back to our safe place... I still got it on my bedstead. I do think about, I do hold it a lot.” (Jackie, Group 1, 1-session, PTSD improvement T2 & T3)

The facilitators corroborated participant feedback. One facilitator extolled the importance of introducing this in order to for women to manage states of hyper or hypo-arousal, as she believed this was lacking in the original intervention:

“You can’t do trauma work and hold so narrowly and take people to those places...you are arousing amygdala functioning, and memory and body memories, and then you are expecting them to flit into their cognitive functioning, from their emotional world into their physical world, you know... we did the cleansing, it was ours and we did the comfort kits to support them going into this.” (Facilitator 2)



Her overarching recommendation for improving Seeking Safety focused on a greater balance of holistic coping skills:

“I think I would put in probably more mindful practice, I would put in more physical grounding techniques, like Stephanie Covington’s work, I would do something more around basic yoga, basic breathing... more three dimensional, so it would be about working with mind-body-spirit-emotion.” (Facilitator 2)

This supports the introduction of more sensory based coping skills, and increased repetition of physical grounding techniques already present in Seeking Safety, which would be of immediate benefit to those women with more sporadic attendance and/or active substance use.

## **7.4 Group dynamic**

### **7.4.1 Group Cohesion and therapeutic alliance**

The group dynamic, between participants themselves and between participants and the facilitators, was one of the over-arching themes identified in the qualitative data as influential to the acceptability of the group for the participants. Analysis of their views identified three key positive themes: 1) *bonding through shared experiences*, 2) *hearing from others*, and 3) *peer support*. The negative views were categorised under the themes of: 4) *feeling shut down*, 5) *frustrations with others*, and 6) *tensions between women in different stages of recovery*. Positive and negative views were expressed by women with varying attendance patterns and improvements in PTSD. The views were corroborated through triangulation of the quantitative measure of group cohesion. An additional theme of 7) *growing pains* encapsulates the difference in therapeutic alliance formed between some participants and one of the facilitators, also corroborated by the quantitative measure of therapeutic alliance, and how this changed over the course of the study. These findings are discussed in more detail below.

#### **7.4.1.1 Bonding through shared experiences**

The fact the group was women only was appreciated by the participants because it felt safe and comfortable but also because it was inspiring:

Because it's woman based only, I think in that regards I feel comfortable I really do...I appreciate being in the presence of lots of women, wonderful women, so thank you for that." (Sophie, Group 1, 11-sessions, No PTSD improvement)

"It was just for us, just women there, took more opening up, because the men together can feel shame." (FG\_Gloria, Group 1, 11-sessions, PTSD improvement T2 & T3)

The group bond was aided by the shared similarity of experiences of IPA or '*seriously big experiences*' as one participant put it:

"Cause we were all the same, went through similar things it was nice you know? It was a group of people that were meeting every week same time same place it was really good." (Neesha, Group 2, 7-sessions, PTSD deterioration at T2 & T3)

"Having a safe space for women who have been through the same thing, that understand that yeah... there is a lot of stuff that we go through as women." (Mariella, Group 2, 2-sessions, PTSD improvement T2 & T3)

#### **7.4.1.2 Hearing from others**

Women described how it was helpful to listen to what other's had to say, whether it was related to hearing stories of what others had endured over their lives, their interpretation of the topic matter, or attempts to put in place coping skills. One woman described being encouraged to try other things (e.g., attend another group) after hearing others talk about it. Others stated that it was helpful to know they were not the only ones suffering, even if they didn't know they exact nature of others' trauma, which appeared to play an important role in normalising their experiences:

"What helped me get better was knowing that I weren't the only one going through these symptoms and suffering... I thought I was going mad, you know what I mean, I thought it was the drugs they have sent me mad, but like hearing all the other ladies and their experiences and stuff like that that was a good help, yeah definitely." (Steph, Group 2, 9-sessions, PTSD improvement T2 & T3)

"And yeah just hearing other people, and how different or similar that is related to each people, I guess. I found as I did more, I was enjoying it more and it was really helping me and it was interesting to the group." (Gina, Group2, 8-sessions, PTSD improvement T2)

#### **7.4.1.3 Peer support**

Others gave examples of how the group supported them emotionally, including women only attending a few sessions.

“We were all very close in there and we all did help each other. I loved the group, I did, and although I wasn’t there often I did love it.” (Ali, Group 2, 4-sessions, PTSD improvement T3)

One woman described the ‘weight lifted off her shoulders’ when she shared with the group that she had experienced an emotional breakdown due to the anniversary of her partner’s death, that had caused her to miss sessions. Clare, quoted below, described the groups’ response to the action she had taken to address her hoarding issues:

“...they all cheered cause I was so happy I was able to throw out three bags might not be a big thing to anyone else.” (Clare, Group 1, 8-sessions, PTSD improvement T2 & T3)

For Rachel, she appreciated the support of the group after she had been asked to leave the Abstinence group for slipping up on her drinking:

“I was quite surprised one day... after I had been reprimanded, and everyone was still lovely to me... I was surprised I walked in and I did just burst into tears and I was surprised where it came from but everyone was fine and lovely.” (Rachel, Group 1, 3-sessions, PTSD improvement T2&T3)

However, there was one exception; a participant who only attended the first session, before dropping out, spoke negatively about her group alliance. Having missed the pre-orientation, she reported that that she felt isolated from the group and felt “stupid” because she did not have anything to say, which I noted down in my field-notes. Unfortunately, she was not available for a qualitative interview at T3 where this could have been explored further.

#### **7.4.1.4 Frustrations with others**

Whilst women described a strong group alliance, women were also very vocal about the behaviour of other group members, which impacted on their positive experience of the group. These views were particularly dominant within the group of women attending at least six sessions in Group 2.

Some women stated that the group was more intense when certain women were present, and this appeared to be related to the inconsistent attendance of a few women who were more active in their substance use. The frustrations ranged from feeling like some women were not taking the group seriously, interrupting and taking up the attention of the facilitators because of their ‘dramas.’ The disruptive behaviour included turning up ‘wasted’ from having used the night before, leaving the room constantly during sessions, and talking too much:

“I found that one person in particular was saying the same thing every week and I just felt that they were like just going on too long and wasting that time, that valuable time, cause it was a short group.” (Jasmine, Group 2, 12-sessions, no PTSD improvement)

“All I wanted to say was that it depended on the members of the group that was in there. If certain members weren’t in the group, it was a better group. If other members were in the group it was a worst group.” (Steph, Group 2, 9-sessions, PTSD improvement T2 & T3)

#### **7.4.1.5 Tensions between women in different stages of recovery**

In both focus groups, the views expressed indicated that there was a sense of ‘them and us’ mentality between those attending the Stabilisation and Abstinence structured programme at the study treatment service:

“In all honesty I had seen a few weeks with people from the Stabilisation group here and then 3-4 weeks later they had dropped out and it was abstinence group only, it sort of settled by that point, in honesty, it settled.” (FG\_Jamila, Group 1, 7-sessions, PTSD improvement T2)

“The only negative thing I found and I think I said this to you before, I felt that some people needed a bit more time to offload... it wasn’t a place to really kind of go in your problems, it was more like how to deal with you know a bit more solution based (Jasmine, Group 2, 12-sessions, no PTSD improvement)

Others described finding the presence of certain women a challenge to their own recovery, perhaps because it reminded them of their own behaviour, potentially triggering unpleasant memories:

“...it was difficult for me to watch cause I was quite early on not using and in recovery and to see it and to constantly be like crack crack crack crack or to completely stink of alcohol, you

know, leaving the room to throw up and different things like that.” (Gina, Group 2, 8-sessions, PTSD improvement T2)

However, other women in their individual interviews expressed concern with the dominant dialogue in the focus groups and that the group lacked ‘kindness’ towards those who were struggling more with their substance use:

“I just found that some of the views from some of the other ladies, um a little bit patronising.... I just thought it was a little bit two faced because they said they wouldn’t talk to anyone in the other [Stabilisation] group, or that you shouldn’t have anybody who does this come on to the [Seeking Safety] group, you know it’s a little bit off putting.” (Beth, Group 1, 8-sessions, PTSD improvement T2 & T3)

“But if they are genuinely struggling with their usage but are getting something out of the course then fair enough, do you know what I mean. I think it’s the disruption thing. And because it’s such a massive sensitive subject that really, we are really all on the same level playing field, whether we are clean or only using sometimes, trauma is still trauma.” (FG\_Tara, Group 1, 12-sessions PTSD change at T2 & T3)

The facilitators also expressed concern that allowing an eclectic mix of participants in terms of recovery and stability challenged their ability to maintain a safe group space. They describe one participant, who was abstinent, and who found the presence of others difficult and consequently acted in a hostile manner towards the facilitators and her peers.

“You can see Alda, even though I didn’t like the way she was disrespectful to her peer group you know, I can feel something in terms of what she was saying, this is taking her to another place, she has come in undone by the likes of [lists other participants’ names] and she is in a different space. To bridge that with limited time is incredibly difficult.” (Facilitator 2)

#### **7.4.1.6 Feeling shut down**

Women, in Group 1 and Group 2, described ‘being cut-off’ from speaking by the facilitators as one of least helpful elements of the group. This indicated that the challenges identified in the fidelity monitoring, were reflected in the experience of the participants:

"There was a time when I sat down and I said something's really coming up for me and instead of me getting it off my chest, I was shut down on it. (FG\_Hanna, Group 1, 12-sessions, PTSD improvement T2 & T3)

Some women stated it felt 'hurtful' when they were stopped from carrying on a conversation by the facilitators, particularly when they felt others were allowed more time. One woman described the impact of being asked to come back to an issue later after check-in, which is part of the implementation guidance.

"When you are feeling that vulnerable you need to talk there and then, for someone to say, it's sort of a slap in the face well me personally... I know it's childish so when you do try and talk it's not as clear, you are upset and its almost as though someone's telling you off, shut up, well that was the impression I got." (Clare, Group 1, 8-sessions, PTSD improvement T2 & T3)

However, this concern did not impact her attendance, her enthusiastic praise for the group, or her ability to benefit from it. For another participant, the inability to express herself was directly linked to her desire to attend the group and her ability to benefit from it:

"I don't think I took much from the programme. I sat here and I heard the people saying what ever they want, which is ok I am not against that, but when it was my turn I felt cut out many times, they put me in a place where I couldn't really, it became hard actually you know to start talking...and its unfortunate I took almost nothing from this [group]."" (FG\_Alda, Group 2, 6-sessions, PTSD improvement T2)

The qualitative data was supported by the quantitative measures of group cohesion, the California Psychotherapy Alliance Scale-Group CALPAS-G (Gaston & Marmar, 1994), which was administered at T2. The CALPAS-G contains four subscales, which attempt to measure participant agreement with different aspects of group alliance. **Patient Working Capacity** asks questions relating to the participant's perceived ability to share their thoughts and feelings with the group and deepen understanding about what was bothering them. **Patient Commitment** asks participants to rate how much they feel the therapy was worthwhile, the best way to get help with problems and if there was any resentment about being in the therapy. **Working Strategy consensus** asks whether the participant felt they were working together with other group members in a joint struggle and that others understood what they were hoping to get out of the sessions. **Member Understanding and Involvement** asks participants to rate how much they

felt accepted and respected by the group and how much they felt other group members were able to help deepen their understanding of their difficulties. Participants can score a maximum of 6 for each item however the scores were reported with an additional one pointed added to each subscale in order to standardize with the full CALPAS questionnaire (Marmar & Gaston 1989). Table 14 illustrates the total group scores for the different sub-scales of the measure, with higher scores representing better alliance.

Table 14: Participant scores for group cohesion

<b>Total group (n=18) *</b>	<b>[mean (SD)]</b>
<b>a. Patient Working Capacity</b>	4.41 (1.65)
<b>b. Patient Commitment</b>	5.95 (1.19)
<b>c. Working Strategy Consensus</b>	5.08 (1.40)
<b>d. Member Understanding and Involvement</b>	5.55 (1.24)

\*missing data for one participant

Of the four subscales, the lowest mean score for the total group of participants was provided for **Patient Working Capacity** and the lower scoring on this sub-scale reflects the qualitative feedback above in relation to feeling shut down. **The Working Strategy consensus** and **Member Understanding and Involvement** are reflective of how participants viewed their peers. High ratings for both these subscales suggest the overall positive feedback given in the qualitative interviews with regard to hearing and learning from others and peer support outweighed the negative aspects discussed.

Between group differences were explored in relation to each of the CALPAS-G sub-scales scores provided by Group 1 and Group 2. This was informed by the hypothesis that the facilitators were more familiar with the material when delivering Group 2, which may suggest an improved group experience. Furthermore, women in Group 2 also appeared more vocal about the disruptions to the group dynamic, which may have resulted in a differential scoring. Within group differences in CALPAS-G scores between those receiving six sessions or more and those receiving less than six sessions were also explored. This was informed by the qualitative interview data, which indicated that those attending fewer sessions might have been impacted by the emotional

intensity of the group. The scores for each sub-scale disaggregated by these groupings are displayed in Appendix 33. A Wilcoxon rank-sum test of the medians was performed to assess for these differences, however there was no evidence for the difference in the descriptive scores observed.

#### **7.4.1.7 Growing pains**

Across Group 1 and 2 there were positive views expressed about both facilitators, and this was predominantly among women who attended at least six sessions. Descriptive terms such as 'amazing', 'lovely,' and 'helpful' were used.

"...they were absolutely lovely and you could see they were caring." (FG\_Jasmine, Group 2, 12-sessions, No PTSD improvement)

"...very helpful and nice, when we share something, they give back." (FG\_Gloria, Group 1, 11-sessions, PTSD improvement T2 & T3)

Many women also reflected on how their views of one facilitator changed to positive over time, initially describing her as 'strict' or 'school-like'. Others reflected that time was taken to warm to this facilitator because she was unfamiliar to the service. This quote is reflective of the general sentiment expressed:

"The very first session I found [Facilitator 2] a bit too strict or too kind of harsh. I thought there should be a little bit more kind of, um flexibility, or you know with the kind of people that are coming to the group. But then the second session I found it much better and I appreciated it a lot more cause she [Facilitator 2] does have a lot of knowledge to impart and she is not as harsh as I initially thought she was..." (FG\_Mariella, Group 2, 2-sessions, PTSD improvement T2 & T3)

One woman, who experienced conflict with both facilitators about accusations of drug use early on in the intervention, stated:

"[Facilitator 2] at first she wasn't sure about me but then after a while she warmed to me which was nice. I did have a bit of a crying, shouting fit with her on the second week, but after that it was alright." (FG\_Chrissy, Group 2, 9-sessions, no PTSD improvement)



One woman gave very negative ratings to both facilitators at the interview immediately at the end of the group (T2) but reflected at the T3 interview that she understood the facilitators were trying to keep to a tight schedule and keep things moving and described both as 'lovely'.

The qualitative data was supported by the quantitative measures of therapeutic alliance. The structured questionnaire Working Alliance – Short Form (WAI-SF) provides another description of the therapeutic alliance between participants and facilitators based on: agreements on the therapeutic goals, consensus on the tasks that make up therapy, and a bond between the client and the therapist (Horvath et al. 2011). Table 15 below presents the scores provided by the participants for each facilitator and the test statistic exploring evidence for a difference in the scores. Higher scores (maximum 6) represent a better working alliance.

Table 15: Participant scores for therapeutic alliance with the two group facilitators

WAI-Participant ratings of facilitator (n=17)* [mean (SD)]		Wilcoxon signed rank test
Facilitator 1	Facilitator 2	
4.08 (1.06)	3.64 (1.34)	(Z=2.28, p=0.02)

\*Data from two participants are missing

A non-parametric Wilcoxon signed rank test was performed on the difference in medians to determine if there was any evidence for the difference in scores provided for the two facilitators. This showed evidence for a difference in the median scores (Z=2.28, p=0.02) and corroborates the qualitative data analysis, which identified difference in views expressed among participants' regard for each of the facilitators. This questionnaire was administered immediately at the end of the intervention (T2), and therefore may reflect the more negative views women held about one facilitator, some of which had changed by the time of the 3-month post-intervention follow-up (T3).

The difficulties within the group dynamic expressed by the participants chime with the facilitator difficulties in adhering to certain aspects of the fidelity intervention fidelity, described in 7.2.2 above. The combined views support the idea of maintaining smaller group sizes, as discussed in

initial study design (Chapter 6, section 6.5), particularly given the diversity of group participants, and the learning curve that facilitators experienced in becoming fully competent with the material and delivery format.

## 7.5 Intervention structure

### 7.5.1 General format

The semi-structured interviews identified aspects of the intervention format that women found helpful and unhelpful. Analysis of their responses categorised the negative views under the theme of 1) *unsuitable session pace*. Positive views were categorised under the themes of: 2) *limited trauma discussion*, 3) *one-to-one support from facilitators*, and 4) *unique experience*.

#### 7.5.1.1 Unsuitable session pace

Almost all participants agreed that the pace and timing of the sessions were too rushed, even amongst those who liked the more rigid structure and reported an overall positive experience. Some found the pace distracted from fully understanding the material and absorbing the content of the hand-outs:

“...sometimes there was just read this, or tick this, and cause there wasn’t time, don’t read this, it was all done very quickly, and I had no idea what I was doing.” (FG\_Gina Group 2, 8-sessions, PTSD improvement T2)

“It was just really robotic, that’s what I felt ... it just seemed very rushed and very programmed.” (Ali, Group 2, 4-sessions, PTSD improvement T3)

One woman described how the emotional intensity of the group interfered with her ability to think, which meant a slower pace was needed. This point is highly pertinent issue for those with PTSD due to the neurobiological impacts of trauma:

“Just trying to sit with the feelings that you are feeling while trying to listen to what is being spoken about, and obviously they want you to read a lot of stuff and it just got too overwhelming sometimes, it was just too quick.” (Sophie Group 1, 11-sessions, No PTSD improvement)

Some conceived the problem as related to session length:

“But it went very quickly because we not have long for talk more and you need to read and I think it missed just a little bit of this, more time.” (Gloria, Group 1, 11-sessions, PTSD improvement T2 & T3)

“It would have been nicer to have been a bit longer, two hours it did feel very rushed because um, you couldn’t really stop to say anything, cause the course was this and if they went off track there would not be enough time to finish it.” (Mariella, Group 2, 2-sessions, PTSD improvement T2 & T3)

#### *7.5.1.2 Limited trauma discussion*

Across both focus groups, women supported the guiding philosophy of the intervention format that avoided detailed discussion of trauma; their reasons related to emotional safety as well as session length:

“...some of the traumas that have happened to me, I think I would have been fine talking about it here because everyone has been very supportive and open, I would’ve been fearful of how I would have felt when I got home...because obviously everyone is not there with you at home.” (FG\_Clare, 12-sessions, PTSD improvement T2 & T3)

“Cause if we had gone in more detail about each others’ things... we wouldn’t have actually taken as much in and we would just still feel all that shit.” (FG\_Gina, Group 2, 8-sessions, PTSD improvement T2)

However, Hanna, who was abstinent, stated that the group did not meet her expectations as she had been expecting to go into more depth, perhaps indicating a readiness to proceed with more second stage therapy:

“I thought it would be a lot different in my head as to how the group actually came about. I thought we would be going really in-depth into our traumas and it was going to be...more tearful than it was, a lot deeper.” (FG\_Hanna, 12-sessions, PTSD improvement T2 & T3)

### *7.5.1.3 One-to-one support from facilitators*

The offer of one-to-one follow up support outside of sessions, from one of the facilitators also appeared to play a role in increasing the acceptability of the intervention. This was particularly the case for women who found the group intense:

“...when I came out I made an appointment to see [Facilitator 1], but lucky enough she wasn’t busy that day and lucky enough I spoke to her, it’s just I was feeling a bit overwhelmed...” (Clare, Group 1, 8-sessions, PTSD improvement T2 & T3)

“It was a good idea to have the choice to go and talk to [Facilitator 1] afterwards, and she is a counsellor...I did know that I needed something else after, cause I couldn’t walk away with all those feelings and still having all that emotion on me so I would rather go let it out with someone else, then go and pick up [substances], do you know what I mean?” (Steph, Group 2, 9-sessions, PTSD improvement T2 & T3)

For Jamila, who described having an ‘emotional breakdown’ during the group due to a number of interconnecting factors, the one-to-one support was instrumental for her being able to continue in the group:

“And speaking to her [facilitator name] last week on Thursday, I wasn’t.... you would not have seen me if I hadn’t seen her, none of you would have seen me at all....” (FG\_Jamila, Group 1, 7-sessions, PTSD improvement T3)

However, some women thought the facilitators should have been more pro-active regarding offering the one-to-one support:

“... a lot of people suddenly found themselves talking about stuff they had never talked about which was quite unusual for them, so I just think that if [facilitator] saw that, don’t wait for them to come and ask, tell them would you like an appointment to talk.” (Chrissy, Group 2, 9-sessions, PTSD improvement T2 & T3)

“...or as part of the check-out to say whether you need one-to-one support straight after or set date or time before the next session, and then we can speak to [facilitator] and actually have that in place.” (Jamila, Group 1, 7-sessions, PTSD improvement T3)

### **7.5.1.4 Unique experience**

The combination of the relevant topic matter and overall structure and format of the intervention resulted in a ‘unique experience’ for the study participants, particularly strong among those

attending more sessions, but regardless of whether clinically meaningful PTSD improvements were experienced. The intervention was viewed as superior to other interventions received before, highlighting its relative advantage over other treatment current available for the women.

“It’s completely different, completely different. It was a lot more empowering, yeah. There was a lot more structure to it as well.” (Jamila, Group 1, 7-sessions, PTSD improvement T3)

“It was completely different because we had something to focus on from Monday to the Thursday. When you have got groups here... by the time they do check-in, there is no group, so there was sometimes a waste of time. But in this group study we had to keep it short and simple because we had something to be talking about.” (Beth, Group 1, 8-sessions, PTSD improvement T2 & T3)

“I mean Seeking Safety was literally the best thing that I have seen here... Abstinence is completely different and I don’t take as much from those sessions, from those groups to be honest.” (Gina, Group 2, 8-sessions, PTSD improvement T2)

### 7.5.2 Structural components

Study participants provided high quantitative ratings for the main structural components of the intervention as part of the Seeking Safety feedback questionnaire, as outlined in Table 16 below. The group began with a structured **check-in**, whereby each participant had 2-3 minutes to answer questions regarding how they are feeling, examples of good coping since the last session, substance use or any unsafe behaviour since the last session, and update on commitment and community resource. The **check-out** asked people to share how they were feeling, any problems with the session, their new commitment, and community resource if needed. The **quotation** followed the check-in and involved one participant reading out an inspirational quote followed by a brief facilitated discussion about the main point of the quote. The **commitment** acts like the ‘home-work’ or out-of-session activity, and women were encouraged to identify a task, coping skill, or other activity to attempt before the next session. The **hand-outs** comprise the content for the main body of the session, and include information, quizzes and discussion points.

Table 16: Participant ratings of core components of the Seeking Safety format\*

Check-in/Checkout	Quotations	Commitments	Hand-outs
2.38	2.75	2.50	2.83

\* Based on 14 questionnaires completed at the final session

Women were also asked their views on these different format components at the semi-structured interview. Appendix 34 provides further qualitative data to support the views about these different format components. In summary, some women were appreciative of the shorter check-ins as this allowed time to move onto the core topic discussions, and this was despite the complaints about feeling shut down or moved on when they tried to express themselves in check-in. Only positive feedback was given about the use of quotes. Participants did not have any strong opinions regarding the wording of the hand-outs despite initial concerns by facilitators and myself about the 'American' language and the exercise examples or case studies which may not be a 'fit' for the group. Whilst a few people noted the confusing language, they were mostly described as 'alright.' Participants were more concerned about the pace in which they were used, a general theme for the group experience discussed further below. Across both focus groups, there was agreement that reading the hand-outs out-loud together would have helped people to understand and follow the content. Original concerns held by the facilitators (Chapter 5, section 5.2.3) about the language and nature of the commitments were not born out nor corroborated in the participant qualitative data. In fact, some of the most enthusiastic feedback related to the commitments, which participants were 'encouraged' not 'forced' to do and which appeared to be a key facilitator of action and a BCT that worked for some. The excerpt below, taken from second focus group, illustrates this sentiment:

FG\_Jasmine: I liked the commitments,

FG\_Steph: I liked the commitments as well, they were good,

FG\_Jasmine: I am always like that, I wanted to come back and said I did it,

FG\_Steph: I'm like that,

FG\_Jasmine: so it kept me on track a bit,

FG\_Steph: me too,

FG\_Jasmine: But it was just good cause it made me think when I went home I've got to do this so it kept me, it motivated me to do it.

(Jasmine, Group 2, 12-sessions, no PTSD improvement)

(Steph, Group 2, 9-sessions, PTSD improvement T2 & T3)

### **7.5.3 Recommendations for changes to structure**

#### **7.5.3.1 Slowing down the pace: lengthier intervention**

Participant recommendations for changes to the intervention centred on the best way to ensure a better pace of delivery of the detailed topic content, and in this regard, there were divergent views. Whilst some believed the sessions should have been extended beyond 2 hours, not all agreed for various reasons. For some, the intensity of the sessions meant that longer would have been too overwhelming, and others questioned their ability to concentrate for an extended period:

"I before wanted the sessions to last a bit longer but the longer they lasted they got a bit too deep... I thought it was a bit short but I am happy with the way they did it because it helped me just to think." (Clare, Group 1, 8-sessions, PTSD improvement T2 & T3)

"...there is a lot to digest to take away, and to make it longer might not, concentration goes you know, not everybody is clean at the time." (Rachel, Group 1, 3-sessions, PTSD improvement T2 & T3)

Amongst Group 1 participants there was vocal support for splitting each topic over two sessions. Those in support believed it would help reinforce the learning and provide a way of slowing down the pace of the sessions:

"And I think if it was spread across the two, it was made a bit longer then people would have understood a bit more. Some people just want grasping the same in one go. " (Rachel, Group 1, 3-sessions, PTSD improvement T2 & T3)

The facilitators also held this view:

“...but I think each one of those may be two sessions, for example, and then you would have something, a very very different vibe to it, then maybe two hours and all of those other parameters.” (Facilitator 2)

As detailed in section 7.2.2.3 above, in response to the feedback from participants in Group 1 and the facilitators, the format was changed slightly in Group 2 in order to trial one topic split over two sessions (*Healing from Anger*). However, comments from the end of session feedback questionnaires showed that women in Group 2, who received two sessions, still thought more time was needed, and the topic was scored highly in both groups regardless if one or two sessions were spent on it (2.80 vs 2.75). One woman from Group 2 made a point of stating that she would have preferred longer sessions rather than splitting a topic over two sessions:

“I couldn’t remember what did we talk about, who was the last person who spoke about something, you know if it was fluid and just went continuously on, and we finished that topic, then we could have moved onto the next topic.” (Neesha, Group 2, 7-sessions, PTSD deterioration at T2 & T3)

Both the facilitators and participants agreed that the twice-weekly sessions worked well. The quote below from one of the facilitators elucidates why:

“...it meant that they were really in the zone, quite connected. It was very affirming because they had the beginning and the end of their week kind of held in that space.” (Facilitator 2)

The mixed views regarding session length and topic length indicated no clear preference. There was more general support for running a longer group beyond 12-sessions, something that was requested in both focus groups and by the service manager:

“I think the general consensus is that it wasn’t long enough. Obviously, this was just a sort of trial or whatever but I think if you did it more it would have to be longer.” (FG\_Chriissy, Group 2, 9-sessions, PTSD improvement T2 & T3)

“...actually what that tells me is if the programme is run to the full manual, for a much longer period of time, those women could have really benefited from it cause they benefited from it in a really short amount of time.” (Service Manager)



One of the facilitators suggested running a longer pre-orientation group to prepare some women for the structure and focus of the main Seeking Safety group:

“...and what you would need maybe, is like a pre-programme...so they are used to that way of thinking, that you have reinforced safety safety safety, how you can manage yourself, like a real pre-orientation to that [Seeking Safety] group.” (Facilitator 2)

## 7.6 Summary

From the original target sample size of 24, 19 out of 21 eligible women recruited attended at least one Seeking Safety session, with 68% (n=13) completing at least six sessions (minimal dose) and 16% (n=3) attending all 12-sessions. Overall women completed an average of 7.2 sessions. 84% (n=16) were followed-up 3-months post-intervention (T3). Two women withdrew from the study before completing any sessions; one woman could not be assured of confidentiality due to her daughter volunteering in the service, and her friend also withdrew because of this. Women reported multiple experiences of life-time IPA, and substance use severity varied, with over half of women reporting abstinence at baseline. Participants found the study measures acceptable and relevant, and although some found the interviews distressing, no-one required follow-up support from staff afterwards. Attendance at the pre-orientation was an important element in helping women to feel comfortable with each other and the facilitators, and promote continued attendance, however, women reporting more severe substance use at baseline struggled to attend, which they attributed to their active use.

Intervention acceptability for the participants was largely influenced by the group dynamic. Feeling cut-off by the facilitators, and disruption and domination of the group from those with more active substance use, were the over-riding complaints. Women felt that the pace of the sessions was too fast and overly focused on getting through the content, and women consequently felt unable to fully express themselves. Both participants and facilitators recommended spreading topics over two sessions and delivering a longer group and endorsed small group sizes. Despite the negative aspects, women were emphatic about the uniqueness of the group and relevance of the topics, particularly grounding techniques and addressing anger. All the structural components were

supported, particularly use of inspiring quotations and out-of-session activities to practice coping skills, 'the commitments.' The introduction of the new components, the mind-body activities comprising a sensory based 'comfort' kit for self-soothing, and ending ritual involving a fragrant spray, were particularly valued and deemed helpful. The provisions of one-to-one discussions with facilitators outside of the group were also important due to the intensity of the subject matter, the availability of which could have been re-iterated more to the group participants. The provision of a space solely for women with shared experiences of IPA also appeared crucial for normalising individual experiences and supporting mental health improvements. Women described the group as less relevant for addressing their substance use. Facilitators believed the group held potential and identified similar criticisms to the participants, which were highly influenced by their negative experience of undergoing fidelity monitoring. They required substantial preparation time for sessions, more experiential training, and ongoing coaching. Attempts to address this as part of the study were limited by pressures on facilitators' time which meant additional training could not be provided as hoped.

The findings from this study have shown that it is feasible to recruit and deliver Seeking Safety in a substance use treatment service in England, and that overall participants and staff found the adapted intervention content acceptable.

## Chapter 8: Feasibility Study Results: part two

This chapter presents exploratory analysis of participant outcomes at follow-up (objectives 6-7) and explores the wider contextual considerations that may have impacted on these outcomes (objective 4vi). The data comprise analyses of the study outcome measures and wrap-around service utilisation data as well as analysis of the qualitative interview data from individual interviews and focus groups, predominantly with the group participants. In line with the mixed-methods design, the presentation of the results move between quantitative and qualitative data in order to provide completeness, further explanation to some results, and to confirm and discover hypotheses formed from the qualitative data. As with all feasibility studies (Eldridge et al., 2016; Arain et al., 2010), the aim was not to assess effectiveness or test hypotheses, nor did the sample size allow for this. Rather, the sample selected was purposive to reflect the over-arching objectives focused on acceptability (Eldridge et al., 2016). Therefore, a cautionary approach must be taken to interpretation of statistical analysis, with limitations heeded (discussed in Chapter 9, section 9.4.6).

As with part one, quotes from interview participants are followed with a descriptor comprising [Name<sup>41</sup>, Group 1 or 2, number of sessions attended, and whether clinically meaningful improvement in PTSD symptoms (>10 point change on PCL-5) was recorded at T2 & T3].

### 8.1 Participant outcomes: quantitative measures

#### 8.1.1 Introduction

Intention to treat analysis was performed on the outcome measures with last observation carried forward used for the 3 participants with missing data at follow-up. Table 17 illustrates the change in mean scores over time (T1=baseline, T2= immediately post-intervention, T3= 3-months post-intervention) for the measures of PTSD, depression, emotional regulation, self-esteem, coping

---

<sup>41</sup> Participants' real names have not been used in order to protect anonymity. Quotes taken from focus groups are preceded with 'FG' before the participants' names.

skills, and social support, and the associated test statistics. These changes are also represented graphically in Figures 16 & 17. The change in scores for PTSD, depression and emotional regulation illustrate similar patterns: the mean scores between baseline and both T2 and T3 indicate improvement but no evidence for any of the changes observed between T2-T3. The change observed in scores of self-esteem, coping skills, and social support also illustrate similar patterns: but lacked statistical evidence for these changes.

### **8.1.2 PTSD symptoms**

A one-way repeated measure ANOVA test showed there was strong evidence that the group, on average, experienced improved PTSD symptoms over time (represented by a decrease in scores) [ $F(2, 36)=16.68, p<0.001$ ]. Post-hoc tests illustrated a significant reduction in PTSD symptoms from baseline (T1) to immediately post-intervention (T2) ( $53.95\pm13.79$  vs  $35.89\pm17.17$ ) which were maintained at the 3-month post-intervention follow-up.

### **8.1.3 Clinically meaningful change in PTSD symptoms**

Psychometric work on the PCL-5 is currently underway to determine validated cut-off points and measures of reliable and clinically meaningful change. Because these scorings are expected to be in a similar range to those calculated for the PCL-IV (Weathers et al. 2013), current guidance for the PCL-IV was followed in this study using a change in score of 10 points as the minimum threshold for clinically meaningful change and a score below 33 as the cut-point for PTSD. The average mean score at T3 [34.74 (SD 18.46)] was just above this clinical cut-off point for PTSD: 63.16% ( $n=12$ ) of group participants experienced clinically meaningful change at T2, and 68.42% ( $n=13$ ) at T3<sup>42</sup>. However, if accounting for a score below 33, and symptoms no longer qualifying as PTSD, then 36.84% ( $n=7$ ) and 31.58% ( $n=6$ ) would qualify as meeting these criteria at T2 and T3 respectively.

---

<sup>42</sup> These categories were the assigned attributes for the qualitative analysis regarding PTSD improvement

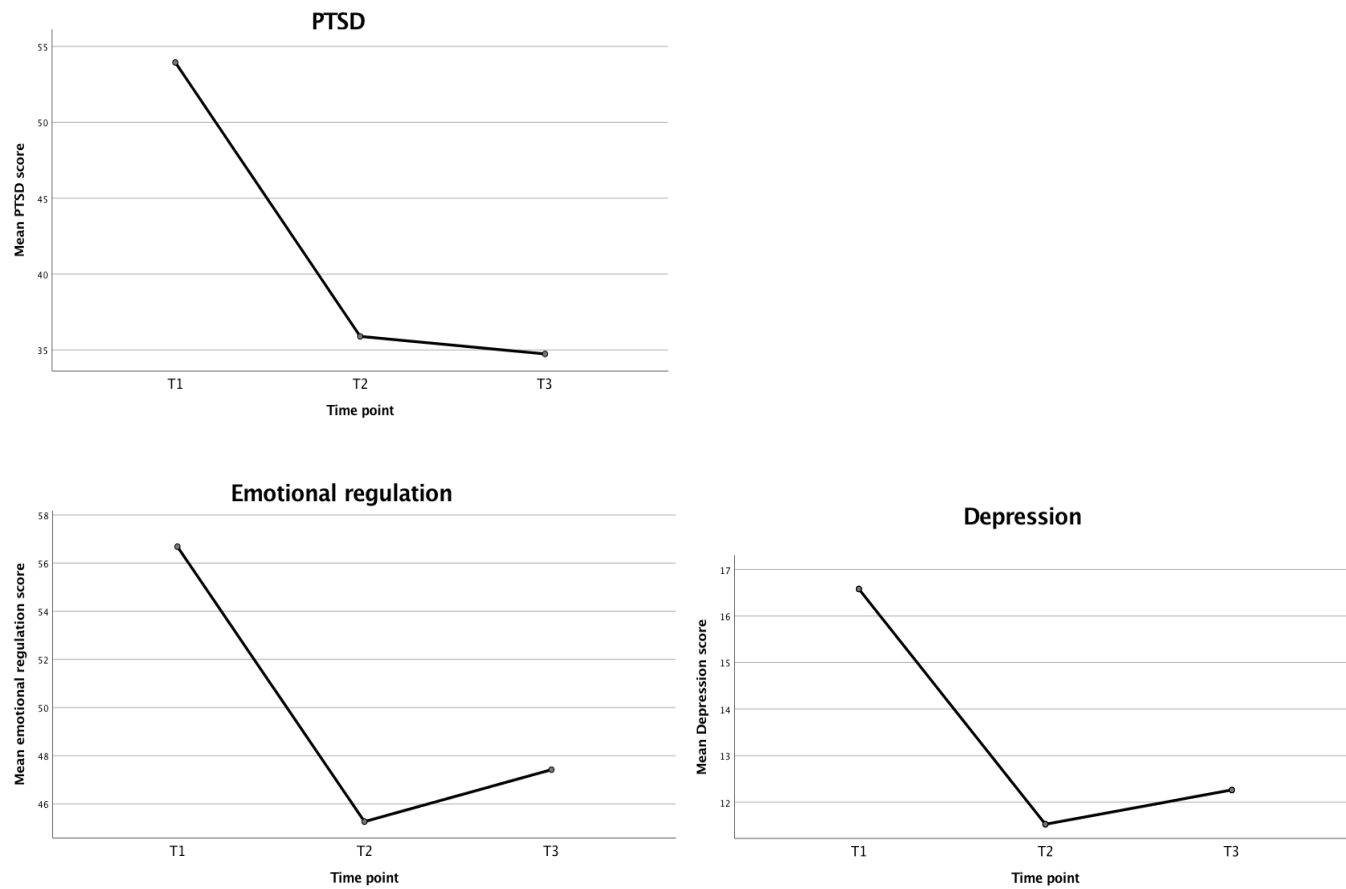


Figure 16: Improvements over time for PTSD, depression, and emotional regulation scores (lower scores representing improvements)

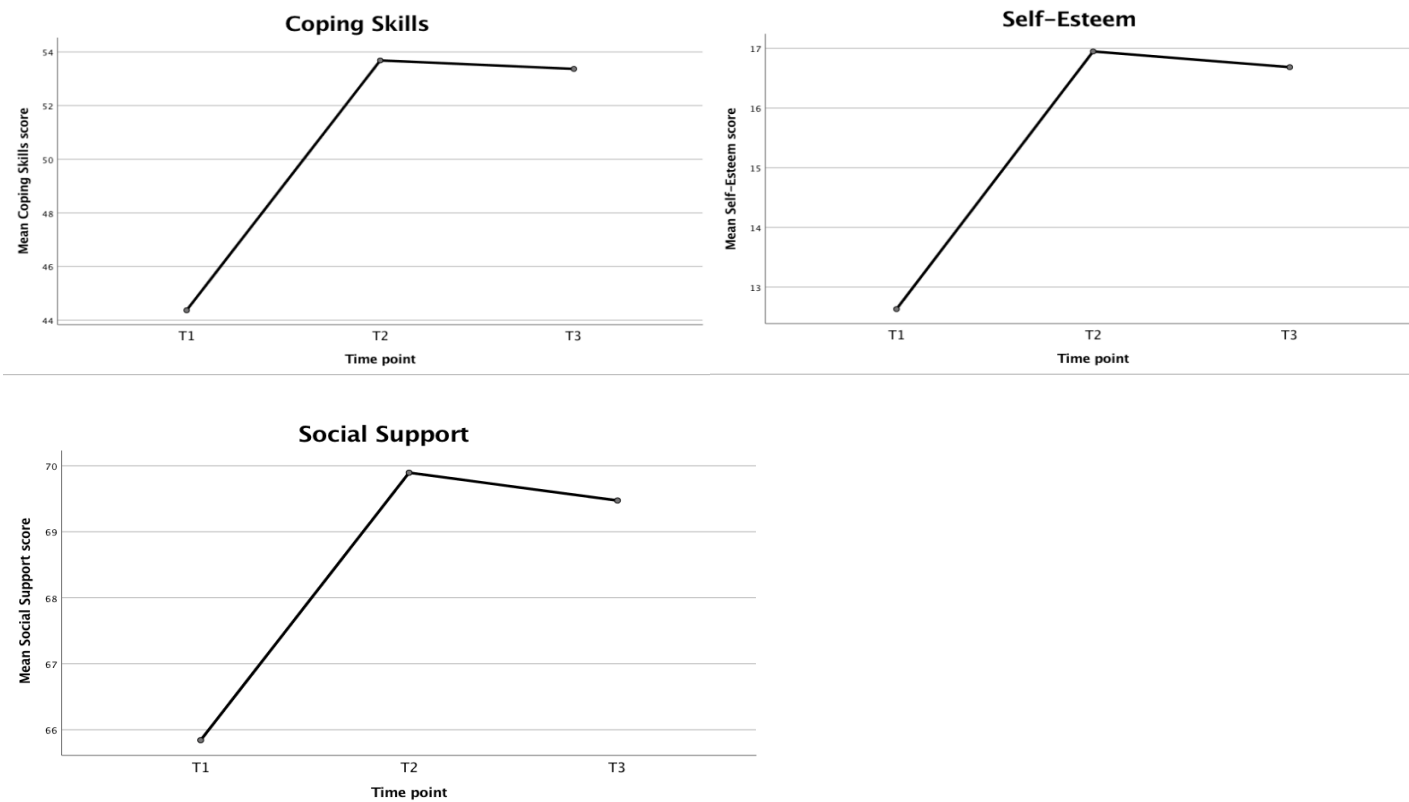


Figure 17: Improvements over time for scores of coping skills, social support, and self-esteem (higher scores representing improvement)

Table 17: Summary and test statistics for study measures using repeated measures ANOVA

Variable (mean, SD)	T1	T2	T3	Repeated measures ANOVA [F(df <sub>time</sub> , df <sub>error</sub> )]	T1-T2	T1-T3	T2-T3
					Mean difference, (SE) (95% CI), p-value <sup>43</sup>		
<b>PTSD symptoms (PCL-5)*</b>	<b>53.95</b> (13.79)	<b>35.89</b> (17.17)	<b>34.74</b> (18.46)	<b>F (2,36) =16.68,</b> <b>p&lt;0.001</b>	<b>-18.05 (3.88)</b> <b>(-28.29 to -7.82)</b> <b>p=0.001</b>	<b>-19.21 (4.23)</b> <b>(-30.36 to -8.06)</b> <b>p=0.001</b>	<b>-1.16 (2.97)</b> <b>(-9.01 to 6.69)</b> <b>p&gt;0.999</b>
<b>Depression symptoms* (PHQ)</b>	<b>16.58</b> (5.19)	<b>11.53</b> (7.41)	<b>12.26</b> (7.91)	<b>F (2, 36) = 7.24,</b> <b>p=0.002</b>	<b>-5.05 (1.24)</b> <b>(-8.32 to -1.79)</b> <b>p=0.002</b>	<b>-4.32 (1.60)</b> <b>(-8.53 to -0.11)</b> <b>p=0.043</b>	<b>0.74 (1.45)</b> <b>(-3.09 to 4.56)</b> <b>p&gt;0.999</b>
<b>Emotional regulation* (DERS-SF)</b>	<b>56.68</b> (14.21)	<b>45.26</b> (16.92)	<b>47.42</b> (16.28)	<b>F (2, 36) =7.84,</b> <b>p=0.001</b>	<b>-11.42 (3.29)</b> <b>(-20.10 to -2.74)</b> <b>p=0.008</b>	<b>-9.26 (3.55)</b> <b>(-18.64 to -0.11)</b> <b>p=0.054</b>	<b>2.16 (2.18)</b> <b>(-3.60 to 7.91),</b> <b>p&gt;0.999</b>
Self-esteem (higher score is better self-esteem)	12.63 (4.95)	16.95 (6.54)	16.68 (6.53)	F (1.34, 24.12) <sup>44</sup> =6.39, p=0.012	4.32 (1.50) (0.35 to 8.28) p=0.030	4.05 (1.64) (-0.27 to 8.37) p=0.070	-0.26 (0.75) (-2.23 to 1.70) p>0.999
Coping Skills (higher score is more coping skills)	44.37 (17.22)	53.68 (24.18)	53.37 (23.18)	F (2, 36) =3.26, p=0.050	9.32 (4.48) (-2.52 to 21.15) p=0.157	9.00 (4.32) (-2.39 to 20.39) p =0.155	-0.32 (3.57) (-9.73 to 9.10) p>0.999
Social Support (higher score is more social support provision)	65.84 (11.00)	69.89 (10.75)	69.47 (13.08)	F (2,36) =1.63), p= 0.210			

(significant results in bold)

<sup>43</sup> Bonferroni correction applied to correct for multiple testing ( $\alpha = 0.017$ )<sup>44</sup> With Greenhouse-Geisser correction applied to account for lack of sphericity of the data

### 8.1.4 Change in PTSD symptoms according to number of sessions attended (minimal dose)

Informed by the qualitative data, the quantitative data were explored graphically to investigate whether a decrease in PTSD scores varied by group attendance. The line graph (Figure 18) suggests that women who attended six sessions or more (i.e. the minimal exposure dose set in the study protocol, Chapter 6) experienced greater improvements in PTSD symptoms over time compared to those attending less than six sessions. A repeated measures ANOVA was conducted, with a between subject factor for minimal group dose, to determine if there was any statistical evidence for this difference. The test did not show any evidence for this interaction meaning that it is not possible to infer to a general population the difference observed in the sample data [ $F(2, 36) = 0.07, p = 0.936$ ]. However, given the small sample size any interaction would unlikely to be detected because the sample was underpowered.

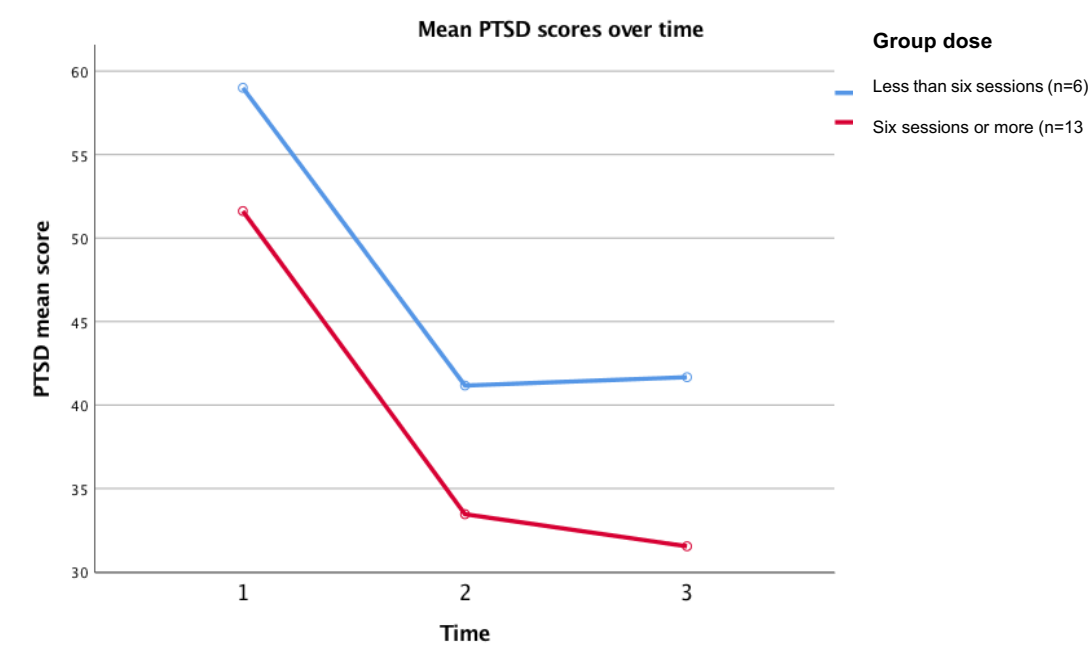


Figure 18: Improvements in mean PTSD scores over time according to group sessions attended

### 8.1.5 Emotional regulation and depression

Repeated measures ANOVA tests showed strong evidence for an average group improvement in emotional regulation [ $F(2,36) = 7.84, p = 0.001$ ] and depression [ $F(2, 36) = 7.24, p = 0.002$ ]. There



was no statistical evidence for the slight deteriorations seen between the end of the group (T2) and at the 3-month post-intervention follow-up (T3) indicating that the improvements seen immediately at the end of the group were maintained at the 3-month follow-up.

#### **8.1.6 Coping skills, social support, and self-esteem**

Repeated measures ANOVA tests showed no evidence for an improvement in scores for social support and coping skills. A positive trend was observed for self-esteem: although the ANOVA test evidenced improvement [ $F(1.34, 24.12) = 6.39, p = 0.012$ ], applying the stricter  $\alpha = 0.017$ , to avoid type 1 error in the post-hoc tests, showed no evidence for the improved scores.

#### **8.1.7 Correlations between coping skills and PTSD symptoms**

As detailed in section 8.1.2.3 below, the qualitative data showed improved coping skills by women experiencing a range of PTSD symptoms improvement. This prompted further investigation of the quantitative data to explore correlations between these two measures. Pearson's correlation indicated strong evidence for a negative correlation between coping skills and PTSD; this means there was evidence for an association with increased coping skills and decreased PTSD scores when both measures were taken immediately at the end of the group T2 ( $r(17) = -0.582, p = 0.009$ ) and at the 3-months post-intervention follow-up (T3) ( $r(17) = -0.643, p = 0.003$ ). Figure 19 illustrates this correlation for both variables measured at T3.

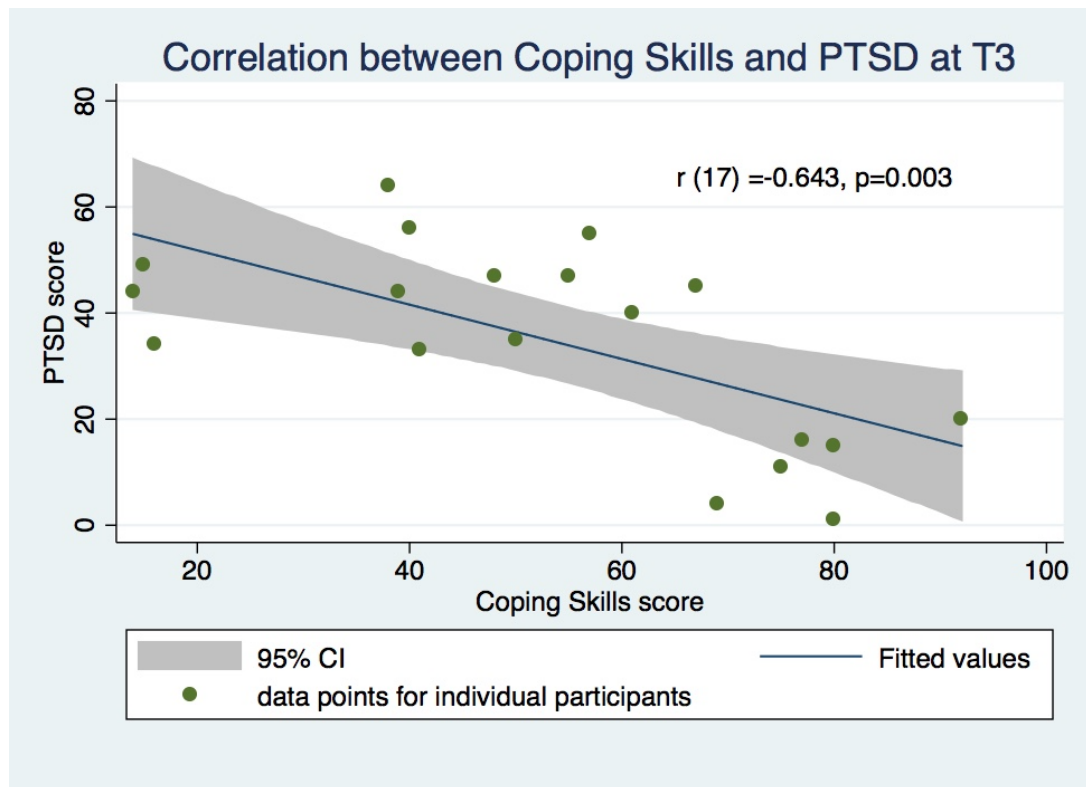


Figure 19: Correlation between copings skills and PTSD symptoms at 3-months post-intervention follow-up

### 8.1.8 Correlations between depression and PTSD symptoms

In section 8.3.2.2 women described ongoing challenges with depression. This finding prompted further analysis of the quantitative data to explore if the measures of PTSD and depression were correlated. Pearson's correlation identified a positive correlation between the scores of PTSD and depression, in that lower PTSD scores were associated with lower depression scores, when measured at the end of the intervention (T2) and at the 3-month post-intervention follow-up (T3). Figure 20 illustrates the strong correlation seen at T3, with depression explaining 80% of the variance seen in the PTSD scores ( $r(19)=0.90, p<0.001$ ). One of the PTSD symptom clusters in the new PCL-5 is closely aligned to depression symptoms, so this relationship may be somewhat expected.

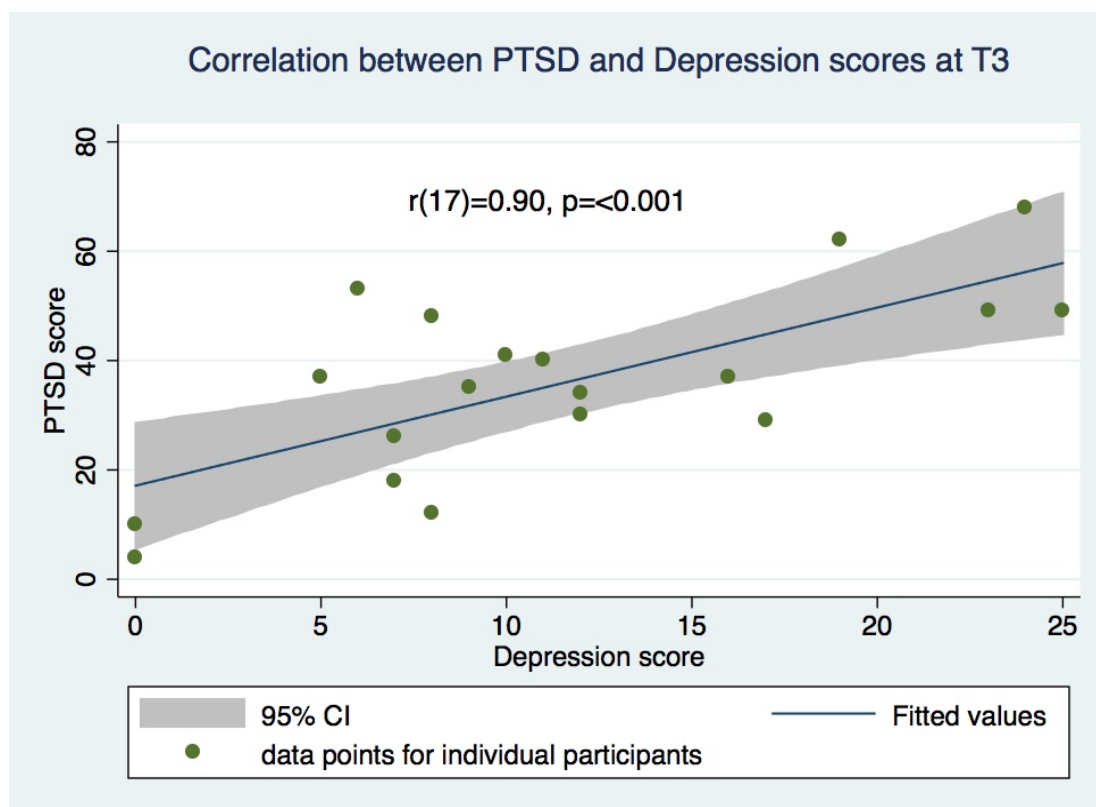


Figure 20: Correlation between PTSD and Depression scores at 3-months post-intervention follow-up

### 8.1.9 Drug and alcohol use

The mean ASI alcohol composite scores over the three time-points were as follows: (T1)=0.15 (SD 0.22), T2=0.07 (SD 0.17) and T3=0.10 (SD 0.21). Due to asymmetry in the data, a non-parametric test was used to assess for change in median scores over time, and this showed weak evidence for an improvement in alcohol use scores [ $\chi^2(2)=28.816, p=0.051$ ]. Post-hoc tests identified an improvement in alcohol use scores from baseline (T1) to immediately end-of-group (T2) (0.04 vs 0.01,  $p<0.01$ ). Figure 21 displays the change graphically using box plots to mark the median and inter-quartile ranges (boxes and whiskers) and the outliers (represented by dots) at each time point. This figure shows decreases in alcohol scores from baseline (T1) to post-intervention (T2) with this decrease weakened at the 3-month post-intervention follow-up (T3).

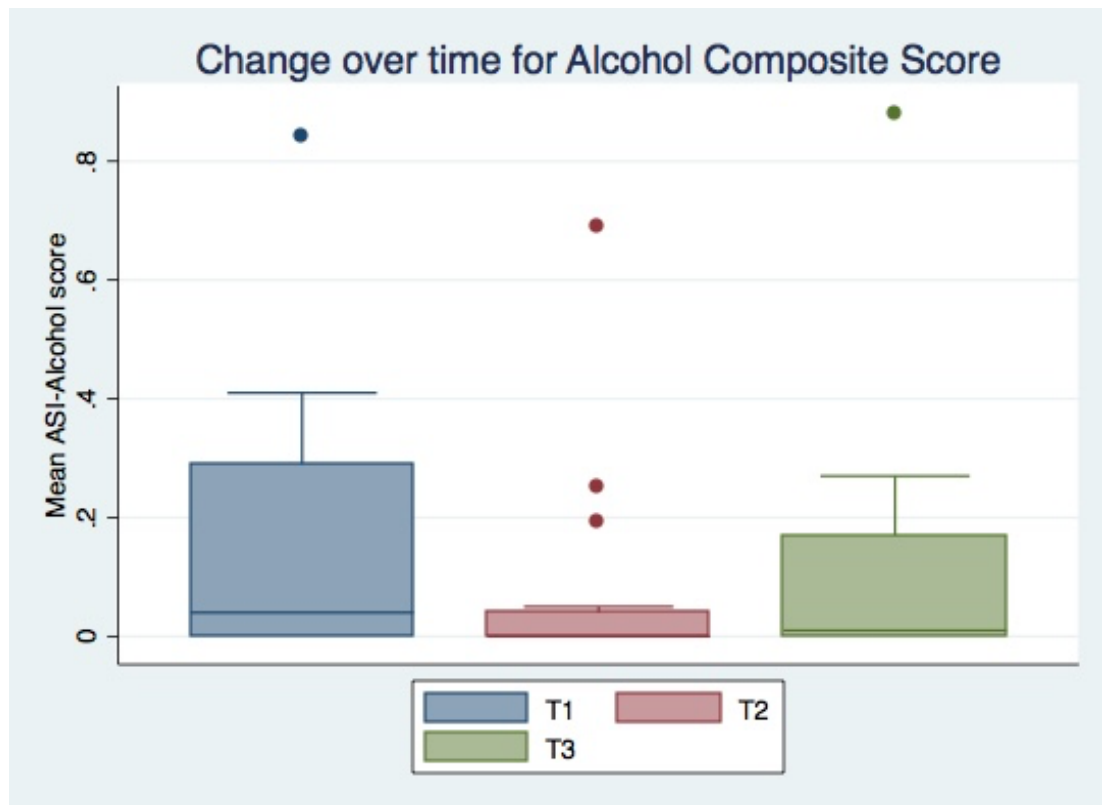


Figure 21: Box plots for the improvements in alcohol use scores over time

Mean ASI drug composite scores at the three time points indicated very little change: T1=0.11 (SD 0.14), T2=0.11 (SD 0.14), and T3=0.10 (SD 0.12), confirmed by non-parametric tests. There was also no evidence for change in median scores in days of drinking or drug use over time within the group. Appendix 35 provides details of the test scores.

#### 8.1.10 Negative trauma cognitions

A non-parametric test was used for the measure of negative trauma cognitions (an ordinal variable), which showed strong evidence for improvements over time [ $\chi^2(2)=37.312$ ,  $p=0.005$ ]. Post-hoc tests showed decreases in negative trauma cognition median scores from baseline (T1) to immediately end of group (T2) (5.22 vs 3.67,  $p<0.008$ ), which were maintained at the T3 follow-up (see Appendix 35). Figure 22 displays this change graphically.

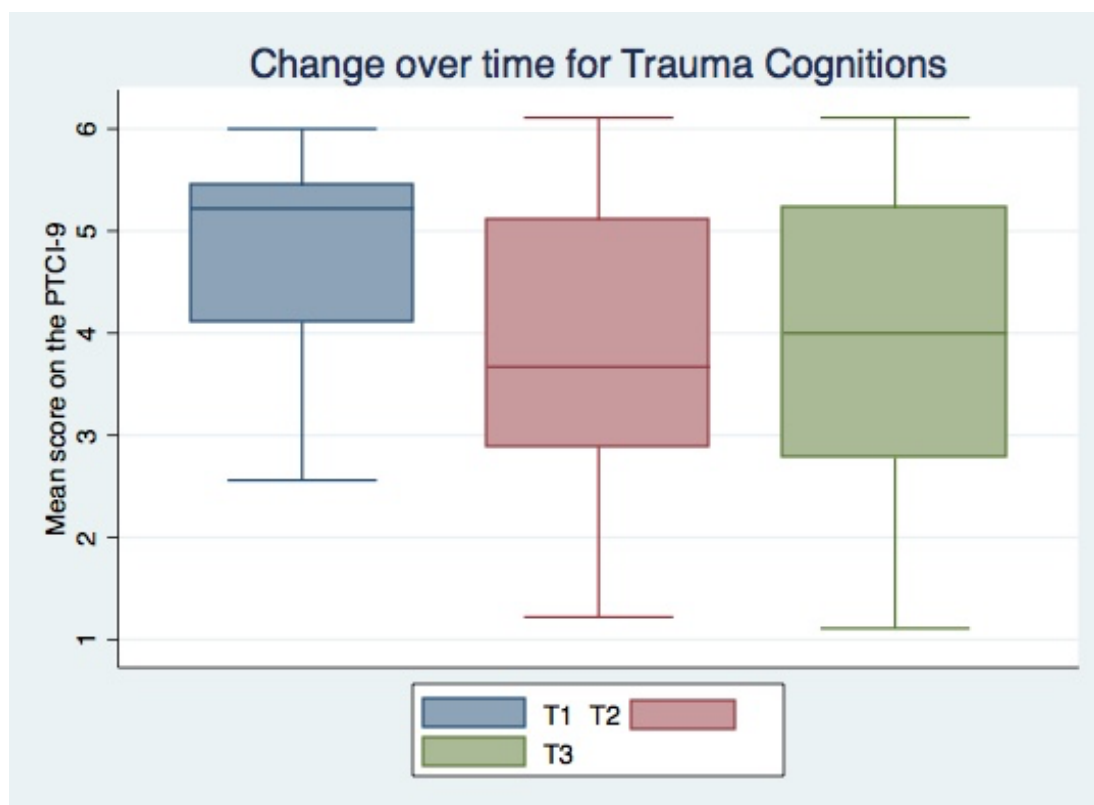


Figure 22: Box plots for the improvement in negative trauma cognitions over time

### 8.1.11 Exposure to recent IPA on PTSD outcomes

Given the high level of repeated IPA reported by participants at both study follow-up points (see section 8.3.4 below) and the potential of these to exacerbate PTSD symptoms, the quantitative data were revisited to explore for this relationship. A repeated measures ANOVA for the PTSD outcome was conducted including a between subject factor for new exposure to abuse following baseline (recorded at either T2 and T3). This determined if women who reported any new IPA since the baseline assessment differed in terms of PTSD outcome compared to those not reporting any new abuse. The profile plot illustrates that in this sample, there was a difference in the mean PTSD scores between the two groups (see Figure 23). It suggested that the women who reported no new IPA during the study experienced greater decreases in PTSD scores, falling below the PTSD cut-off point score of 33, which was maintained at the 3-month post-intervention follow-up. However, there was no statistical evidence for an interaction between IPA and time [ $F(2,32)=1.630$ ,  $p=0.212$ ] indicating that generalisations cannot be inferred. Although, given the

small sample size any interaction would unlikely to have been detected because the test was underpowered.

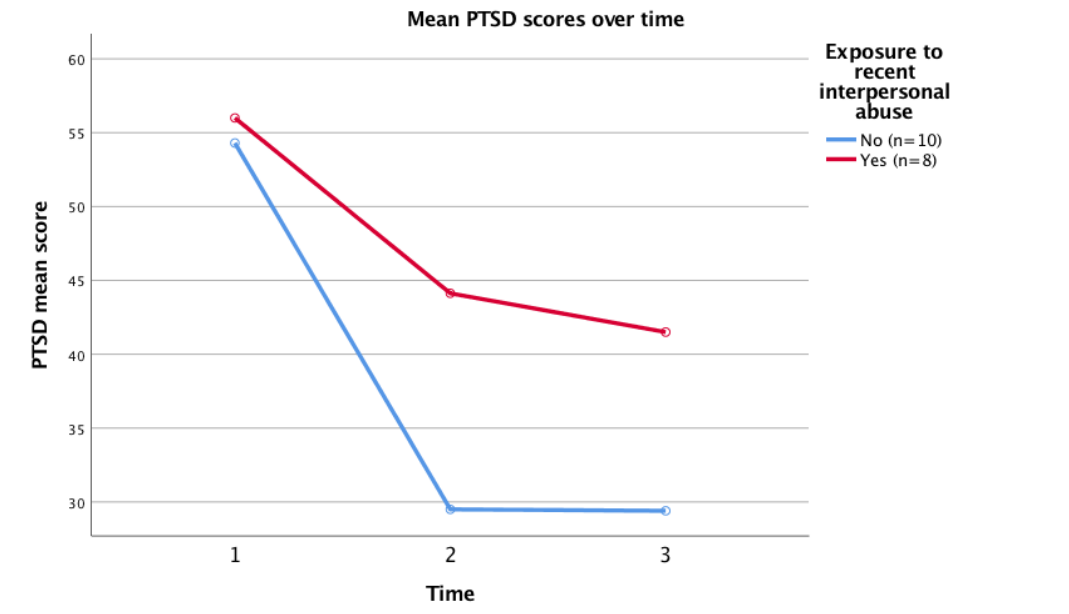


Figure 23: Improvements in mean PTSD scores over time according to new exposure to IPA since baseline

The next section builds on these results in order to provide qualitative data to further corroborate or contradict these findings.

## 8.2 Participant outcomes: Qualitative data

### 8.2.1 Introduction

Some women were extremely positive about the benefits gained from attending the group as illustrated by the quotes below:

“I don’t say this very often but it’s unlike anything I have ever experienced this course. I know that it has changed my life and so I am sure that it has done that to some others in the same group as me. And so it’s so important that this can be experienced by so many many women...”  
(Tara, Group 1, 12-sessions, PTSD improvement T2 & T3)

“I feel great for coming. For myself I was down looking like very deep and very dark, and then from this I saw some hand that pushed me up, because if I don’t have this help, I was still the same.” (Gloria, Group 1, 11-sessions, PTSD improvement T2 & T3)

Women were asked in the interviews whether they noticed any changes in themselves since finishing the intervention and how they coped with mental health symptoms, substance use craving or other stressful events. The qualitative data corroborated much of the quantitative data regarding improvements to mental health and emotional wellbeing, but also expand the findings further to suggest why these improvements came about, and aspects of the intervention that played a role. Where positive improvements were described, women also demonstrated how the new coping skills learnt in the group had helped with these. Whilst the quantitative analysis (section 8.1.6) showed no evidence for improved coping skills, women described a whole range of strategies including cognitive (e.g. new relationship to thoughts, cognitive restructuring), behavioural (e.g. asserting boundaries, self-nurturing), and body-based strategies (e.g. physical and sensory grounding techniques) reflective of those captured in the quantitative measure, and which they attributed to learning from the group. Moreover, the qualitative data also evidenced how these key coping skills contributed important behaviour change techniques (BCTs) identified in the Seeking Safety review (Chapter 5) or were BCTs in themselves, for example *behavioural practice/rehearsal* or *self-monitoring their behaviour*.

Analysis of the qualitative data identified that the over-arching themes dominating descriptions of women's improvement were related to: 1) *improved emotional wellbeing* and 2) *relationship with others*. There were more mixed experiences under the theme of 3) *substance use changes*. Many of the positive views regarding improvements and helpfulness of the group were expressed amongst women attending six or more sessions and who experienced clinically meaningful change in PTSD. Figure 24 provides an illustrative map of these interpretive themes and their sub-themes, which are discussed in more detail below.

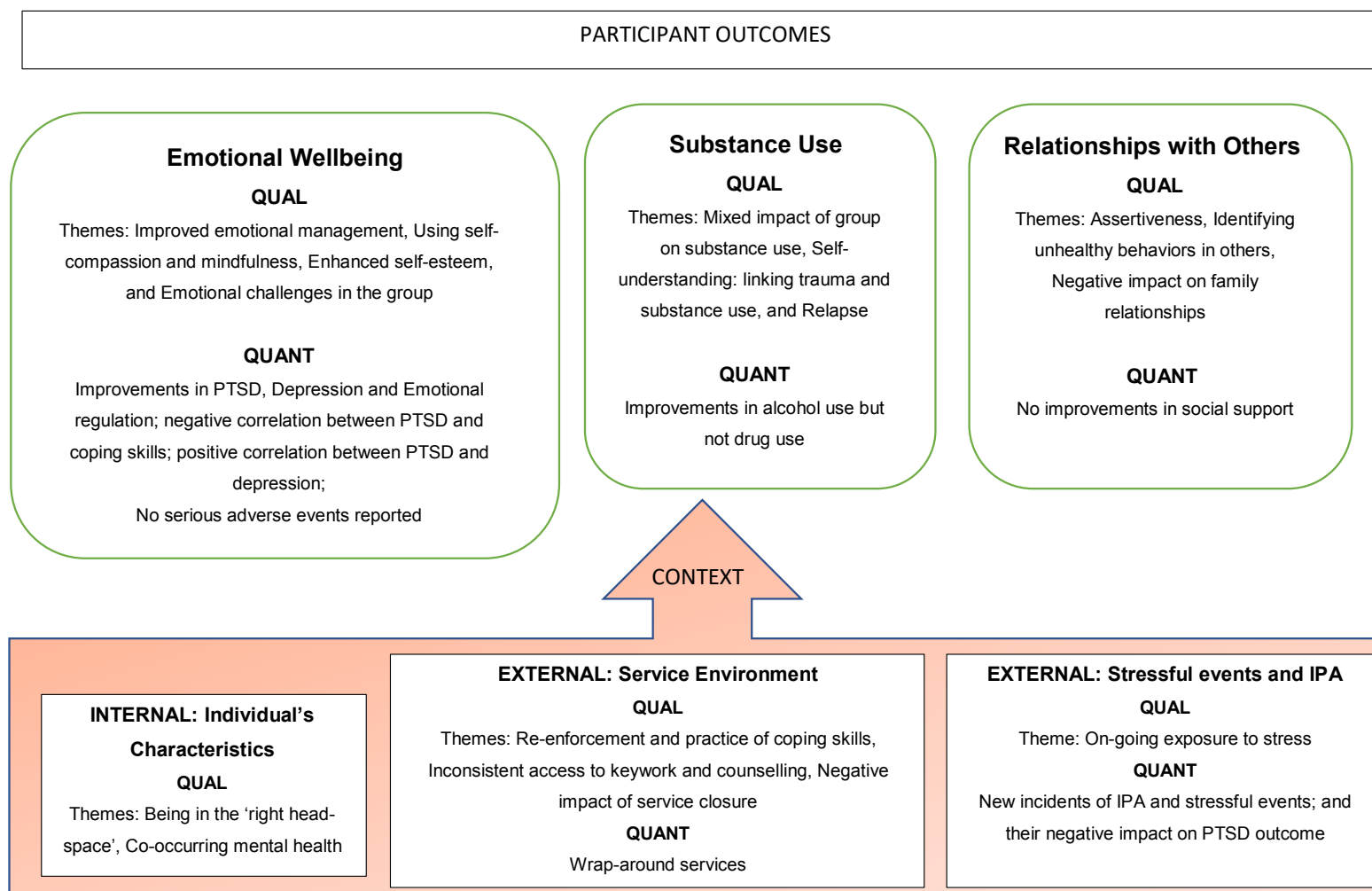


Figure 24: Thematic map illustrating participant outcomes and contextual factors impacting on outcomes



## 8.2.2 Emotional wellbeing

One of the over-arching aims of the intervention was to address PTSD symptoms. The narratives of women who experienced clinically meaningful change in PTSD illustrate how this aim was met, describing improvements across various symptom clusters, for example, re-experiencing:

“You know my PTSD is like kind of curbing a little bit if I am honest, I feel like it is reducing. I am not getting so many nightmares, not getting so many flashbacks, you know I am not hearing him as much, just stuff like that.” (Steph, Group 2, 9-sessions, PTSD improvement T2 & T3)

“I haven’t had any nightmares, I have had a few deep sleep nights now and something happened, something triggered something you know out of the session because if I wasn’t here, it would have still carried on.” (Clare, Group 1, 8-sessions, PTSD improvement T2 & T3)

Another symptom of PTSD is exaggerated beliefs relating to self-blame for the trauma:

“Yes because always I felt guilty that maybe I did something wrong... no I didn’t because someone did to me and this I learnt there.” (Gloria, Group 1, 11-sessions, PTSD improvement T2&T3)

“It was just that shift in taking that blame from yourself, that was what I would say overall the biggest [change].” (Rachel, Group1, 3-sessions, PTSD improvement T2 & T3)

In terms of understanding the potential mechanisms which contributed towards their more positive mood and improved emotional wellbeing, analysis provided further interpretative sub-themes of: 1) *improved emotional management* and 2) *compassion and mindfulness*, and 3) *self-esteem*. A fourth theme identified *emotional challenges experienced in the group*.

### 8.2.2.1 Improved emotional management

Women provided descriptions of their behaviour which demonstrated improved emotional literacy, as well as improved abilities to manage negative emotions. This reflects the improvements in emotional regulation captured in the quantitative measure (DERS-SF) and also confirms that the BCT *reduce negative emotions* is an important focus of the Seeking Safety intervention. These views were expressed predominantly among women who had improved PTSD at either of the follow-up points, and attended more sessions:

“I can stop myself from going from extremely irritated to being calm, I can change the way I feel quicker than what I did before. I’ve never been able to do it before and obviously it’s how we handled it in the group, I can 100% say it has helped me because before it would take me longer to get rid of the [trauma] thought and of course I would get more angry.” (Clare, Group 1, 8-sessions, PTSD improvement T2 & T3)

Many of the statements about managing emotions also followed or preceded the examples of the new coping skills learnt. Gloria, quoted below, refers to one of the visualisation exercises discussed in the group:

“My emotion, they help a lot this...look I have one big suitcase full of problems, and the group was showing me how to open and take this crappy stuff out, yeah this I feel was helpful to put my whole shit away, sorry my language... I can carry my bag and I don’t have extra things heavy. Big step.” (Gloria, Group 1, 11-sessions, PTSD improvement T2 & T3)

Tara attributed the strategies she had learnt on the course, related to self-nurturing and action planning, for mitigating against the negative impacts of the sexually explicit verbal abuse she had experienced by a delivery driver, following the end of the group:

“Previous to this course this would have had me in bed for weeks, it might even of had me going to the doctors to be honest with you for some diazepam because my nerves were a bit shot, I ain’t gonna lie.” (Tara, Group 1, 12-sessions, PTSD improvement T2 & T3)

Having experienced the abuse that day she woke up at 2am not being able to sleep from anxiety, so she decided she needed to nurture herself:

“I said do you know what love, you just need the comfort, so I did I had my bath, put on new (py)jamas, I made a bed on the sofa and as the film started... when I was laughing with the film I realised that I had made such the right decision in nurturing myself.” (Tara, Group 1, 12-sessions, PTSD improvement T2 & T3)

Across participants in Group 1 and Group 2, the coping skills used most frequently after the group ended were those from the *Grounding* topic. This reflects the feedback given previously about the most helpful topics from the intervention (see section 7.3.1).

“There is one thing that I do, I do almost daily that, what do you call it, I don’t know if it’s grounding, but the one where we go to our happy place... and then I come back and life carries on, yeah

you know, but does help, I do it quite a lot actually" (Gina, Group 2, 8-sessions, PTSD improvement T2)

Like mental grounding is difficult for me because I still have like now and then my own voice that is tripping me up, so that goes on, so doing the physical grounding has been really good." (Jamila, Group 1, 7-sessions, PTSD improvement T3)

Women also described how the sensory-based strategies, including the new components added to the standard Seeking Safety intervention, helped manage their symptoms:

"I used to get such bad panic attacks and anxiety...I would spray like a scarf and if I feel panicky I could have a sniff and nobody knows what you are doing, but it sort of just takes you to step away from that chaos at the moment." (Rachel, Group1, 3-sessions, PTSD improvement T2 & T3)

"Every day, every time coming here on the tube, on this packed train, I would never have been able to do that before, I used to get anxiety I would take the long way... but now I can get on the tube and I use the breathing and the smells." (Sophie, Group 1, 11-sessions, no PTSD improvement)

Jamila, who has periods of psychosis, explained how the use of deadlines, learnt from the 'commitments' component of the course, helped her slow down her thought processes in her daily life:

"Yeah before my head was all over the place, I have to do this, I have to do that, I have to do this. So I was spiraling out of control it was like I needed to slow down. Like I say making realistic deadlines, commitments, was a lot better, much much better." (Jamila, Group 1, 7-sessions, PTSD improvement T3)

Sophie quoted below had a difficult ongoing relationship with her mother and described the positive impact of a communication strategy she had learnt in the group, which she attributed to lessening her self-harm on that occasion:

"So I learnt from Seeking Safety to reflect it back on that person and then they can see better what I am trying to let them see, instead of going around in circles, I was actually proud when I did that with her.... and she got it completely... so at least it wasn't just put down the phone, got upset and then I went off and did self-harming or anything" (Sophie, Group 1, 11-sessions, no PTSD improvement)

### 8.2.2.2 Using self-compassion and mindfulness

Women also described as helpful, the ability to be more 'mindful' of their thoughts and feelings:

"I am aware you know when I am feeling down of the tools I can use and it is all about mindfulness, it's all about being in the moment, actually understand what being in the moment means now...I get it, it really has helped." (Clare, 8-sessions, PTSD improvement T2 & T3)

"They still pop up in my head, they still hurt um...Yeah I suppose I am more aware and more, I know they will pass. And I don't have to hold on to them, and I think that is the difference, I can let it go." (Jasmine, Group 2, 12-sessions, no PTSD improvement)

"But this [Seeking Safety] was more about your actions before or sometimes after, because even if you are not taking any substance, you can still watch your reactions, or responses, to certain things, and that helps a lot." (Sophie, Group 1, 11-sessions, no PTSD improvement)

The statistical analysis illustrated improvements in negative trauma cognitions, for the group as a whole (section 8.1.1.8). The qualitative data also illustrated that for some women, employing the coping skills to reframe negative cognitions about themselves, and taking a more compassionate approach to themselves because of IPA experiences, helped to take away the emotional charge of the negative beliefs: the BCTs of *re-attribution (of blame)* and *valued self-identity* therefore appear also particularly pertinent to the success of the Seeking Safety intervention:

"Um so yeah, so the impact that it has had on me is that previously I would have been like 'oh you fucking idiot, get it together' but I thought actually recognising what it is [abuse], how it has affected me." (Tara, Group 1, 12-sessions, PTSD improvement T2 & T3)

"...oh yeah me, I am a lot calmer, I don't fly off the handle as quick...Yeah it has just given me a bit more hope and more understanding about myself and give compassion to myself and stuff, instead of beating myself up all the time." (Steph, Group 2, 9-sessions, PTSD improvement T2 & T3)

Rachel described how she used to call herself a fat cow when she was eating too much and reflected on why that may be the case, in order to change it:

"I think of ex's and things that they have said and I think that is another person's voice, you have taken on that voice, you were called that when you was a kid." (Rachel, Group 1, 3-sessions, PTSD improvement T2 & T3)

For Rachel, taking the time to step back and reframe the negative self-talk in this way made a crucial difference in managing her drinking.

"...that 5 minutes I could have been in Tesco's buying a bottle of vodka but actually stopping and thinking, putting it in its place takes the power out of it in a way and gives you the power." (Rachel, Group 1, 3-sessions, PTSD improvement T2 & T3)

Other participants, particularly those who did not experience clinically meaningful change in PTSD, also reflected on the further support needed from a longer intervention:

"Anger was my major one which I find it hard to express, hence why I use the pills or my eating behaviour or my self-harming it comes in, anger was my major one I had to deal with. Still learning to deal with it." (Sophie, Group 1, 11-sessions, no PTSD improvement).

"...I am not convinced I don't know it's got better (PTSD), I just understand it more...yeah I might liked to have done a longer bit, just to see how much of my drug addiction is something down to that or whether it is down to my ADHD." (Chrissy, Group 2, 9-sessions, no PTSD improvement)

#### **8.2.2.3 Enhanced self esteem**

Women expressed views of themselves that indicated they had assumed a more positive sense of self-worth as a result of attending the group. This was seen particularly among those attending more sessions, providing additional evidence for the trend seen in the quantitative data. This change, closely linked to reduced self-blame and guilt, was expressed in many different ways, for some it was recognising their rights to be treated in a certain way:

"So the course has really helped me to stand my ground and have the conviction and knowledge and belief that you know that I am a decent person and I have the right to be treated in a decent way, that it's not ok um, you know to be spoken to in such a disgusting way...it really has opened my eyes to my own worth you know and really feeling it from deep within." (Tara, Group 1, 12-sessions, PTSD improvement T2 & T3)

"Yeah self-esteem, although my self-esteem wasn't that low if I am honest, like it is a little bit, uh, but I always tell myself that it is not kind of thing, so I am quite strong that way, but it [Seeking

Safety] did definitely help with that definitely.” (Gina, Group 2, 8-sessions, PTSD improvement T2)

Others described feeling more in control and confident accompanied by a realisation that their identities ‘were not all bad stuff.’ This woman reflected on the link between her self-esteem and unhealthy behaviours such as drinking.

“Yeah the better my self-esteem is the further I am away from any sort of harm at all, that’s how I feel yeah.” (Jamila, Group 1, 7-sessions, PTSD improvement at T3)

Clare said she still struggled with telling herself that she is a nice person, however she also said she felt empowered being with all the women in the group and hearing their strengths, once again indicating the importance of groups comprised of women with shared experiences and struggles:

“It certainly made me think we are a power unto ourselves women are, because I have always felt that second class citizen to a man. You think they are all mighty, but actually they are not, we are just as strong and I carry that with me everyday, believe it or not.” (Clare, Group 1, 8-sessions, PTSD improvement at T2 & T3)

#### **8.2.2.4 Emotional challenges of the group**

Chapter 7 described the emotional challenges experienced in the group, due to the group dynamic and intensity of the subject matter, which meant the group was experienced more negatively by some women. In addition, a few women, all in Group 1, described worsening PTSD symptoms as a result of taking part in the group, mainly due to the memories that were being triggered:

“In the beginning it was a bit disturbing because it brought back memories and I had some flashbacks and some horrible feelings.” (Clare, Group 1, 8-sessions, PTSD improvement T2 & T3)

Two women from the same group described having a flashback or surfacing memories in the session, which left them feeling vulnerable:

“There was a time when I sat down and I said something’s really coming up for me and instead of me getting it off my chest, I was shut down on it.” (FG\_Hanna, Group 1, 12-sessions, PTSD improvement T2 & T3)

"There was one time, I was a bit upset I had a flashback of something that I had buried really deep...and it was something I didn't share or say that I had but it was something, that of all the things, it just came out of no-where in my head." (Rachel, Group 1, 3-sessions, PTSD improvement T2 & T3)

Another woman described having an 'emotional breakdown' which she originally blamed on the group but realised it was due to many things, including coming off her psychosis medication. In the focus group she explained:

"I blamed coming in for the groups for this happening and it was like as if I was trying to say to myself that coming to the groups has caused this otherwise if I didn't come to the groups then I would have, you know, been strong and having your barriers up and holding onto things and protecting yourself." (FG\_Jamila, Group 1, 7-sessions, PTSD improvement T3)

However, some of these same women also improved in their PTSD symptoms at one or both follow up time-points, and were thankful for taking part in the group:

"I think the breakdown for me has happened at the right time and I think it is because of doing the groups, it has led me to that [one to one counselling]." (FG\_Jamila, Group 1, 7-sessions, PTSD improvement T3)

"...for me personally because I have done it [the group], I can say right I'm cured but it took me going through horrible nightmares things in my head." (Clare, Group 1, 8-sessions, PTSD improvement T2 & T3)

### **8.2.3 Changes in substance use**

When asked about any changes noticed in themselves since doing the group, women discussed substance use related changes the least. Analysis of women's responses identified two sub-themes related to 1) *mixed impact on substance use*, 2) *Self-understanding: linking trauma to substance use*, and 3) *Relapse*.

#### **8.2.3.1 Mixed impact of the group on substance use**

This excerpt from the focus group conducted at the end of Group 1 illustrates two different views about the impact of the group on substance use:

“FG\_Rachel: Well mine increased because I did pick up [alcohol] but I can’t just put that down to the group, that could have just been me full stop you know, I can’t actually put the blame there....I can’t actually comment on that to be honest” (Rachel, Group 1, 3-sessions, PTSD improvement T2&T3)

FG\_Hanna: Well I can and it didn’t, it didn’t make me want to go and use you know so, I suppose it did work on that front. I didn’t pick up [substances].” (Hanna, Group 1, 12-sessions, PTSD improvement T2 & T3)

One woman, who attended only a few sessions in Group 2, was using crack and alcohol heavily at the T2 assessment conducted immediately at the end of the group. At the 3-month follow-up, she described her internment in jail as the reason for her vastly reduced substance use, illustrating how other factors external to the group, explained outcome improvements. It may also explain a reduction in IPA, and subsequent improvement in PTSD symptoms at the 3-month post-intervention follow-up (T3), at which point she had been in prison for 10 weeks.

#### **8.2.3.2 Self-understanding: linking trauma and substance use**

Some women spoke about the more positive impact of the group on their substance use, for example, Steph quoted below was using heavily just before starting the group:

“Yeah since doing the group well you know I’ve remained clean, not using any substance and that is mainly down to the group as well.” (Steph, Group 2, 9-sessions, PTSD improvement T2 & T3)

Some women were able to link these improvements to new realisations of the links between their substance use and experiences of trauma, and PTSD, and this was predominantly among women attending six or more sessions. This highlights the importance of providing psycho-education about PTSD, as a form of BCT *providing information about antecedents*. Steph, quoted above, went on to say:

“It has helped me a great deal, it’s helped me to understand myself...just why am I like this and what’s brought it up and stuff like that, so I am coping so much better, so much better it’s amazing , it is [laughs] I can’t believe it [laughs].” (Steph, Group 2, 9-sessions, PTSD improvement T2 & T3)



This excerpt from an interview transcript illustrates how Neesha had changed a previous avoidant coping strategy and this helped her to remain sober during the period of the group. This was despite deteriorating PTSD symptoms:

“KB: and how do you find your cravings now?

Neesha: nothing, I don’t even think about it. And this is really strange because before I had the Seeking Safety and the drama therapy I was always, I would go a few days without drinking then I would go on a mad one and then you wouldn’t see me for weeks, it was for some reason not like that this time.

KB: why do you think that?

Neesha: I am dealing with the situation [the abuse] that is what it is. I am not blocking it out, I am actually talking about it and I am, I mean I am not ashamed because it happened, I can’t change it but what I can try and do is deal with it.” (Neesha, Group 2, 7-sessions, PTSD deterioration at T2 & T3)

Other women described important realisations about how their substance use was linked to their trauma:

“I hadn’t thought before about post-traumatic stress at all, um I had never really linked anything together...I hadn’t really realised that deep down probably everything that I had been through [child abuse] was why I was continuing to act the way I was and do the excessive amount of drugs that I used to do and to the extent, you know the way I was living was disgusting.” (Gina, Group 2, 8-sessions, PTSD improvement T2)

“KB: and how is that different from before the group?

Chrissy: I do think making me aware that he is traumatising me, that is trauma that I don’t need, he is not helping me... sometimes [before] I would be in a situation where his arguments would make me think, tomorrow when he has her [daughter], I am going to fucking go and smoke crack...” (Chrissy, Group 2, 9-sessions, No PTSD improvement)

Jamila described how in the group she had experienced increased PTSD symptoms resulting from memories triggered in the group and how this impacted on increased cravings. However, at the 3-month post-intervention follow-up (T3) she experienced clinically meaningful PTSD improvement and also spoke about reduced alcohol cravings, which she attributed to coping skills she learnt in the group:

“Jamila: I feel I have become stronger to manage substance misuse.... I don’t have cravings anymore so that is the plus side of things but otherwise, if you had asked me 3-months ago, I did have cravings back then. But this time around there are no cravings at all, so really proud of that actually.”

KB: that’s really good to hear. Do you feel like any of the content in the sessions helped you with those changes, or would you say it was due to other external things?

Jamila: I think it was to do with the programme itself, I think when it was talking about having a commitment and you had to pick two commitments, I think that helped me to actually live in the now, that was really helpful.” (Jamila, Group 1, 7-sessions, PTSD improvement T3)

### **8.2.3.3 Relapse**

Two women who were positive about their ability to manage substance use post-intervention (T2) went on to relapse during the 3-month post-intervention follow-up period (T3). The participant quoted below, and has been quoted several times earlier, was the only one who reported worsening PTSD symptoms at both follow-up points and had relapsed heavily in her drinking at the T3 assessment. She attributed this to the abrupt withdrawal of the intensive support she was getting from services due to service closure (discussed further in section 8.2.3). When asked what she was doing to cope with the worsening PTSD symptoms she replied:

“I don’t, I don’t cope [laughs timidly]. Yeah I don’t cope I just drink to block out everything, maybe take a sleeping tablet.” (Neesha, Group 2, 7-sessions, PTSD deterioration at T2 & T3)

### **8.2.4 Relationships with others**

The qualitative data also captured other improvements that were not measured quantitatively. Analysis of the data identified the interpretative themes of: 1) *Improved assertiveness* and 2) *identifying unhealthy behaviours in others*, which are important intermediary steps towards protecting against future IPA.

#### **8.2.4.1 Assertiveness**

Women described being more assertive as a result of doing the group, a behaviour implicated in improved self-esteem. Two of the topics involved the discussion of boundaries in relationships and how to be honest, and women described the use of this skill with partners, friends and family members.

"To say no, or something, I never say no for people, and now I learn." (Gloria, Group 1, 11-sessions, PTSD improvement T2 & T3)

Chrissy, who had previously described the emotional abuse from her ex-partner as triggering her crack use, went on to say:

"I definitely have become a bit more assertive with [ex-partner] its just that it depends on when I can do it." (Chrissy, Group 2, 9-sessions, no PTSD improvement)

Beth, quoted below, had previously described extensive emotional abuse received by her adult son and stated the group had helped her manage the arguments:

"It has helped, because when I would be like no I am not going to argue I turn my head... sometimes I feel like I really just want to punch him but that is when I am standing up and I just say nope I think you need to go. I am not going to argue, you know." (Beth, Group 1, 8-sessions, PTSD improvement T2 & T3)

Jasmine described learning to be assertive as one of the most helpful parts of the intervention:

"There was one [topic] about being honest, that was really good. And being able to say how I feel at the time, not let it bottle up... I really do believe that it [group] will make a difference in future relationships. And in the ones that I am having now with my mum and my son, you know, yeah cause it has kind of taken some of the guilt away." (Jasmine, Group 2, 12-sessions, no PTSD improvement)

Tara explained how before the group woman took action in response to the abuse experienced by a delivery driver and wrote consecutive letters of complaint to the company, as well as reporting the abuse to the police.

"But I also realised thanks to you lot that I needed to take control of the situation which is why I initially wrote this letter.... Previously I would have felt like right, that's because you are thick, that's because you just let people walk all over you, you know you are an idiot you deserved him saying that, he can see something in you that is clearly wrong" (Tara, Group 1, 12-sessions, PTSD improvement T2 & T3)

#### 8.2.4.2 Identifying unhealthy behaviours in others

Participants from Group 2 raised an issue in their focus group that illustrated an awareness about unhealthy behaviours in others. One woman attributed this to the group, perhaps due to the topic focused on healthy relationships:

“FG\_Steph: Can I just say this is Seeking Safety and we have had a little issue with a man, a male client shall we say, um like trying to be a bit of a predator.....

FG\_Jasmine: I think that incident with the guy, I think the fact that we have done this [Seeking Safety], kind of helped because we are all a bit more aware, it was clearer to see cause he had obviously seen us out there and he slipped out of his groups to come join us and we all stood up and walked away.”

Some woman described being more aware of the unhealthy behaviours in intimate relationships, for example:

“You know the group, did kind of, we all realised that we need to remove the thing that is making it worse you know or do your best to do that. And you might find you are alright on your own, you don’t need that.” (Chrissy, Group 2, 9-sessions, no PTSD improvement)

Steph reflected that her move away from her abusive ex-partner into a safer and healthier social network, including peers within the 12-step programme, contributed towards maintaining recovery:

“I’ve got lots of other people around me, and I am not in the environment with people that know him [abusive partner] and take drugs with him or anything like that.” (Steph, Group 2, 9-sessions, PTSD change at T2 & T3)

Neesha, however, described a negative impact on her relationships with family members due to acknowledging her experiences of child abuse, in the group. She described thinking differently about the family members who were complicit in her abuse, ‘people she could blame’, and illustrated a change in family dynamic that suggests more support will be needed going forward. This same woman had previously described using avoidance strategies to cope with the abuse, and her refocus on her experiences, combined with the emotions and thoughts directed at family members, may also explain the deterioration in her PTSD symptoms:

“Before I had the therapy [Seeking Safety] I was alright, I could talk to them you know the people that were involved [in the abuse] but during, I just saw them in a different light. I saw them and it just made our relationship really strained.” (Neesha, Group 2, 7-sessions, PTSD deterioration T2 & T3)

## **8.3 Contextual factors**

### **8.3.1 Introduction**

Chapter 5 outlined the importance of considering contextual factors (i.e. external to the active ingredients and components of the group intervention) impacting on behaviour change interventions, and which may need addressing as part of the intervention and/or measured in evaluation. Some of the measures used in this study were chosen to capture variables that could potentially act as moderators or mediators to treatment outcomes, which could be explored in future research of the Seeking Safety intervention with larger sample sizes. Analysis of the qualitative data also identified three interpretative themes which appeared to influence women’s recovery, internal factors: 1) *individuals’ characteristics*, and external factors 2) *service environment*, and 3) *stressful events and IPA*. They feature in the illustrative map (Figure 24), along with their sub-themes, and are described further below, with the associated quantitative measures presented alongside where appropriate.

### **8.3.2 Individuals’ characteristics**

Women expressed a variety of views about their own internal characteristics that influenced their ability to put into practice, and benefit from, the skills learnt in Seeking Safety. These comprised the sub-themes of: 1) *being in the ‘right headspace’* and 2) *co-occurring mental health challenges*.

#### **8.3.2.1 Being in the ‘right headspace’**

Active substance use by some participants was discussed earlier in relation to poor group retention (section 7.1.4) and negative group dynamic (section 7.4). Several women who were abstinent from substances when starting the group reflected on the group timing that married up with their stage of recovery:

"I strongly believe this group came into my life at the right time, because I think, you know, with being an addict in recovery and having a small amount of time being recovered, you know." (FG\_Tara, Group 1, 12-sessions, PTSD improvement T2 & T3)

One woman was grateful she attended the later second group as she was in a more stable place with her substance use:

"I was on holiday so I didn't do it [the group] first time but I am quite glad I did it this time because I would have been in a slightly different space... I think you know it's difficult enough trying to like do something like this I guess ...like if you are unstable it could send you to use." (Gina, Group 2, 8-sessions, PTSD improvement T2)

Another woman who dropped out of the first group, and was using crack and heroin heavily at that time, shared this sentiment after completing the second group:

"I weren't in the right headspace to do it last time cause I was still in addiction, now I am not in addiction, I am in recovery and so my way of thinking and my mental health is a lot clearer. So I can take things in a lot more and understand a lot more and you know my disease don't fight it all the time." (Steph, Group 2, 9-sessions, PTSD improvement T2 & T3).

Women with better attendance held conflicting views about the readiness of those actively using substances. However, not all felt this way. Rachel, perhaps reflecting on her own relapse during the group, highlighted how women less advanced in their recovery could find the group helpful in other ways:

"They may be thinking that maybe my trouble drinking or using or whatever is related to some post-traumatic stress, right now I'm not in the right place but a couple of months down the line, I know that I felt safe in that space, I know that I can go the next time it comes back around." (FG\_Rachel, Group 1, 3-sessions, PTSD change at T2 & T3)

Some of participants with better attendance recommended that in the future research women should be assessed to ascertain if they are ready for the group:

"...so the choosing of the females in the group, it definitely has to be people who do want to participate." (Sophie, Group 1, 11-sessions, no PTSD improvement)

"Maybe in summary, if someone is still actively using for there to be a more in-depth assessment with them to try to gage whether it is appropriate for them at that time, you know and the support around them." (FG\_Tara, Group 1, 12-sessions PTSD improvement T2 & T3)

### **8.3.2.2 Co-occurring mental health challenges**

Some women described ongoing co-occurring mental health challenges such as depression and anxiety. Some mentioned these in relation to the challenges faced in practicing the coping skills learned in the group. Some woman said they struggled to remember to do the grounding exercises when they were grappling with other mental health symptoms:

"But sometimes I don't, I can't explain my brain but sometimes I have got involved in another depressing thought or something else ...it's really a matter of remembering to do it, it's not that I don't think it works, I do think it works, the grounding was good," (Chrissy, Group 2, 11-sessions, no PTSD improvement)

"... it [visualization exercise] does help, I do it quite a lot actually. But it's difficult because I feel you know, I've been feeling quite manic quite the opposite, so I feel I don't know, I find it difficult to do it sometimes or zoned out and the opposite way around." (Gina, Group 2, 8-sessions, PTSD improvement T2)

Sophie described earlier that being more aware of thoughts and emotions resulted in her feeling more in control. However, she went on to say:

"I just wish it could last a bit longer then my negative depressed mind doesn't be devious and say don't be silly." (Sophie, Group 1, 11-sessions, no PTSD improvement)

This feedback reflects the findings in the quantitative data for depression. Table 15 in section 8.1.1.4 illustrated that even though the mean depression scores for the group decreased over time, at both T2 and T3, the mean score remained high, and suggestive of ongoing depression ( $PHQ9 \geq 10$ ) [T2=11.53 (SD 7.41) and T3=12.26 (SD 7.91)]. The statistical analysis also identified that low PTSD scores were associated with low depression scores (section 8.1.1.8).

### **8.3.3 Service environment**

In recognition of the role of ancillary care in supporting positive benefits from psycho-social interventions such as Seeking Safety, a service receipt inventory captured a variety of services

received by women during the study. In addition, the semi-structured interviews, provided more richness regarding how these services were experienced and if they impacted/detracted on the benefits gained in Seeking Safety

#### **8.3.3.1 Wrap-around services**

Data were collected on wrap-around services received by the participants because the presence of additional services, or lack of, was conceived to be a potential moderator or mediator between Seeking Safety and participant outcomes. Group-work and key-work were mostly provided by the study treatment service however some participants attended other substance use treatment services for this. Alternative therapy was also mostly received at the study treatment service and included trauma informed yoga, acupuncture, art therapy, and one-to-one drama therapy. Peer support comprised activities run by the local peer support group and 12-step programmes offered across the borough. Health appointments comprised GP visits and the Specialist Alcohol Nurse. Participants received a large number of these wrap-around services whilst attending the Seeking Safety intervention (reported at T2) and during the 3-month post-intervention follow-up (reported at T3). As outlined in Table 18 below, during the period of the group the participants attended on average 34.8 (SD 24.1) sessions of wrap-around care either from the study treatment service or other substance use or mental health services in the borough. During the 3-month post-intervention follow-up period, participants attended an average of 24.3 (SD 24.5) sessions of wrap-around care.



Table 18: Wrap-around care received by the participants whilst participating in the study

	Sessions received during the group* Mean (SD)	Sessions received during the 3-month post-intervention follow-up** Mean (SD)
<b>All services</b>	34.8 (24.1)	24.3 (24.5)
<b>Group-work</b>	12.2 (13.3)	5.9 (8.0)
<b>Key-work</b>	6.8 (7.5)	4.7 (7.8)
<b>Counselling</b>	1.0 (1.9)	2.3 (4.0)
<b>Alternative Therapy</b>	3.4 (3.3)	1.4 (3.0)
<b>Peer support</b>	7.5 (19.8)	5.1 (15.1)
<b>Health Service Appointment</b>	3.2 (5.2)	4.9 (8.7)

\*Based on data from 18 participants \*\* Based on data from 16 participants

There were large variations in the number of wrap-around services received by the individual participants, illustrated by the large standard deviations. Whilst participating in the group, the number of additional group-work and key-work sessions received by individuals ranged from 0-52 and 0-25 respectively. The number of peer support sessions ranged from 0-84 with two participants accounting for the attendance at the majority of these. This variance is also seen among participants in the wrap-around care received during the 3-months after the group finished.

Women provided a variety of opinions on their experience of the wrap-around services and how this impacted on benefits gained in Seeking Safety. These were interpreted under the sub-themes of: 1) *reinforcement and practice*, 2) *inconsistent access to key-work and counselling*, and 3) *negative impact of the service closure*.

### 8.3.3.2 Re-enforcement and practice of coping skills

Some women indicated how their attendance at the additional services was complementary to Seeking Safety and the symbiotic relationship between these different interventions for reinforcing new coping skills learnt:

"I thought with the Seeking Safety it touched, because it was a group, it touched the surface, but then when I went into drama therapy 1:1, I went deeper into what had been spoken about in the Seeking Safety." (Neesha, Group 2, 7-sessions, PTSD deterioration T2 & T3)

At the moment it is a little bit difficult for me to say because where I was on this other course, I have got myself a little bit confused as to which place I have learnt what tool...[Seeking Safety] was actually like an amalgamation of lots of different coping mechanisms put into one I think, with extra that I haven't learnt before." (Rachel, Group 1, 3-sessions, PTSD improvement T2 & T3)

Only one woman, Steph, who was not enrolled on the other day programmes (Stabilisation or Abstinence) held at the study treatment service, spoke about the value of 12-step programmes, offered externally, in maintaining her abstinence. She attended 84 meetings of 12-step groups during her participation in Seeking Safety, and 60 during the follow up period. In response to a question about barriers and facilitators to abstinence, she replied:

"I am just keeping myself busy, trying to keep to some kind of programme every day." (Steph, Group 2, 9-sessions, PTSD improvement T2 & T3)

Other women, mostly those not enrolled in the study treatment service, reported very little wrap-around care. Jasmine made this comment about her peer who was only attending the Seeking Safety group:

"I feel because you [gesturing to other participant] wasn't in the other groups that you needed space, maybe you would have got more out of it if you were doing other groups, this was your only space." (FG\_Jasmine, Group 2, 12-sessions, no PTSD improvement)

The peer in question also corroborated this view in her interview stating that she needed counselling alongside the group. The facilitators also picked up on this point suggesting running separate groups for women who not enrolled at the study treatment service:

"Cause if you had a group of women who didn't have that extra support work, then work with them as a [separate] group, does that make sense? Then you could adapt the programme to meet their needs." (Facilitator 2)

### **8.3.3.3 Inconsistent access to key-work and counselling**

Women's narratives suggested inconsistent access to key-work. This is important because 'case management' forms a core part of the Seeking Safety intervention, and it is the role of the key-workers to provide this element to the participants. Whilst some women were happy with the additional support provided by the study treatment service outside of Seeking Safety, others expressed discontent. Beth expressed frustration that she had only been able to see her key-worker once during the entire study period despite her repeated requests:

"I am supposed to have someone that I can talk to myself. I actually felt and it made me go back to how I felt when I first came back here, that my problems are not important enough, because I am not banging on about everything all the time." (Beth, Group 1, 8-sessions, PTSD improvement T2 & T3)

She also said the lack of support drove her to leave the service after the group because she felt no-one cared. Gina said she lost trust in a key-worker because she felt not enough had been done to help facilitate a referral to counselling whilst she had been at the service:

"I spoke to (counselling supervisor)...that is what she recommended to me, to have counselling or more in-depth psychological support, so from that, I went (to key-worker) and tried but I am still waiting like for nothing basically. So I kind of just gave up." (Gina, Group 2, 8-sessions, PTSD improvement T2)

As part of the study protocol, the study treatment service agreed to make one-to-one counselling available to all the participants who needed it. This was introduced in the pre-orientation but some of the participants in Group 1 stated in the focus group that either they were not aware that this was available, or there were waiting lists:

"Yeah but I have been put on a list half way through... so I could see [counsellor name], but there is a waiting list... (FG\_Rachel, Group 1, 3-sessions, PTSD improvement T2 & T3)

"I think it was because not knowing at the time that there's more support after each session, say for instance if we were told if you feel that after a session that you need more 1:1 thingy, then maybe it would have helped to actually put it into practice, and actually reinforced what we have learnt." (Jamila, Group 1, 7-sessions, PTSD improvement T2 & T3)

The facilitator from the study treatment service also expressed concern about the inconsistency of key-work offered by some staff, but also highlighted the importance of key-workers being trained in TIP and having awareness of the content of Seeking Safety:

“I think it’s important that’s is what I am saying, cause you can’t really do this work with substance abuse if you don’t have the [key] worker together....what do the clients say to the key-worker if the worker is not clear about trauma it would be quite difficult to make the link, that is the difficult one...” (Facilitator 1)

#### **8.3.3.4 Negative impact of service closure**

The final structured session of Seeking Safety for Group 2 took place on 12 March 2018 with an ending session and focus group taking place the following week. The post-intervention follow-up (T2) interviews were completed by the end of March. The study treatment service closed on the 31 March 2018 due to the re-commissioning of the borough substance use treatment services. At this point, only one of the nine participants who started Group 2 continued into any of substance use treatment or aftercare in the new services. In the qualitative interview data, two women who were abstinent at the post-intervention follow up interviews had relapsed during the subsequent 3-months (T3). They both put their increased substance use down to lack of service support:

“...because I had no-where to go. [Study treatment service] closed you know I was getting used to going there it was like a routine, there were people that I knew there, I got used to the people there, and it sort of suddenly closed, we had places to go, but it wasn’t the same.” (Neesha, Group 2, 7-sessions, PTSD deterioration T2 & T3)

“I mean I was abstinent last time [at T2].... I think it’s kind of been just a mixture really, I guess [study treatment service] closing cause I don’t have any help from any service now...So I kind of just give up but yeah it would be nice to have some support somewhere... like a group I could go to another time.” (Gina, Group 2, 8-sessions, PTSD improvement T2).

Both these women described the substance use treatment service as ‘like a family’ and ‘not just bricks and mortar’ and felt they no longer had support from anywhere. This suggests that for some participants the service had provided an element of social support, not only treatment support. Mariella, who described relapsing back to heavy substance use shortly after beginning the group, expressed disappointment that the group was not continuing and that the study treatment service was no longer available:

"Since I left [study treatment service] I have kind of been drifting by myself really so it would help me to be around people and to do some kind of group or course, cause I feel like I am getting further and further lost." (Mariella, Group 2, 2-sessions, PTSD improvement T2 & T3)

Chrissy commented:

"I think probably some of the girls will probably go back to exactly the same thing [substance use] because they don't have the support." (Chrissy, Group 2, 9-sessions, no PTSD improvement)

Even before the service had closed, there may have been potential impacts on service delivery. The service manager reflected that during the last six months of service operation, staff members were pre-occupied with job security concerns:

"So, I think having a staff team that are not 100% can have an impact...you know, towards the end, 30-40% you were lucky except of course [facilitator from study treatment service]!" (Service Manager)

#### **8.3.4 Stressful events and IPA**

Women reported an average of 2.3 (SD 2.8) (range 0-11) new stressful or upsetting events that happened whilst undertaking the group (measured at T2). Narrowing these to IPA, 45% (n=8) of women reported experiencing at least 1 form of IPA at T2 (range 0-5). During the same period, 47% (n=9) of women reported experiencing any form of intimate partner violence. The qualitative data also identified the theme of *ongoing exposure to stress* and provided further completeness to these quantitative measures describing impacts on wellbeing. The IPA that women described experiencing during the period of the group ranged from emotional abuse to rape and other forms of sexual abuse. One event involved sexual groping in a lift by a stranger in the woman's apartment block. In the majority of the cases, the perpetrator(s) were known to the women and comprised, ex-partners, 'acquaintances' and sons. Beth described the ongoing arguments with her son at each interview time-point which are a constant cause of stress:

"Because he is the one that will put me down that I am no good, that he hates me, I'm a cunt, I haven't done nothing to inspire him... because he will tell me to shut up the minute I go to answer back and I am the adult." (Beth, Group 1, 8-sessions, PTSD improvement T2 & T3).

Ali described the situation with a man who was perpetrating physical, emotional and sexual abuse towards her:

"I kicked him out he just keeps worming his way back in. I am not sure what is happening we are not together we have had intimacy but it's not, it's just get over here and bend over, it's not what I want. I don't know if I am just people pleasing, I don't know what I am doing." (Ali, Group 2, 4-sessions, PTSD improvement T3)

At the 3-month post-intervention follow-up (T3) women reported an average of 1.3 (SD 1.0) (range 0-3) new upsetting and stressful events since the previous assessment. This included Ali, quoted above, being sent to jail for stabbing another man who she said had been harassing her. Jasmine described the recent sectioning of her son and suggested that this may be contributing to lower scores on the mental health measures.

"It was just a shame because of the recent thing with my son [sectioning] that I was, I have actually gone a little bit backwards." (Jasmine, Group 2, 12-sessions, no PTSD improvement)

During the same period, a smaller percentage of women reported exposure to IPA (28%, n=5) and at least one form of intimate partner violence was experienced by 37% (n=7) of study participants. One woman who reported emotional abuse from her partner also expressed concern that she was using physical violence towards him as a result of being triggered by memories of previous abuse. This same woman had also described her partner as being supportive when she was experiencing PTSD symptoms such as flashbacks, indicating the more complicated realities of some women's relationships.

Tara experienced sexually abusive and intimidating verbal harassment by a delivery driver at her apartment. She described him using graphic and highly sexually offensive language towards her, which continued when she argued back:

"And the volatility because I did Karen, I felt at a point he was going to charge at me, because he was absolutely bloody raging Karen." (Tara, Group 1, 12-sessions, PTSD change at T2&T3)

The incident triggered flashbacks to previous abuse experienced by a stranger who had kidnapped and held her hostage and caused extreme states of anxiety, which she said would

have previously confined her to bed for days. Tara was quoted previously in relation to the coping skills she put in place to limit the psychological distress, which she clearly attributed to learning in the group. Gina described having to leave her property and stay elsewhere because of harassment from two separate people. She experienced stalking and property damage by a woman with whom she had a brief relationship as well as repeated abuse from a peer at the study treatment service. She described him as a 'head-case' who had repeatedly been stalking and harassing her by letter, phone and in person outside her house. He had recently turned up at her workplace with presents, which she refused, resulting in him verbally abusing her. She ended the story by saying:

"I tried quite a lot of different ways to get away from him and it's not really worked to be honest."  
(Gina, Group 2, 8-sessions, PTSD improvement T2)

## 8.4 Summary

Overall, improvements were recorded in the quantitative measures of PTSD, depression, emotional regulation, and negative trauma cognitions at the end of the group, which were sustained at the 3-months post-intervention follow-up. Women attending 6-sessions or more experienced steeper decreases in PTSD symptoms, compared to those attending less, although this was not supported statistically possibly due to the small sample size. One of the study objectives set out to explore clinically meaningful change in PTSD which was defined as a minimum 10-point change in the PCL-5 (Weathers et al. 2013). In this regard, 63.16% (n=12) of group participants experienced clinically meaningful change at T2, and 68.42% (n=13) at T3. However, at both follow-up points more than half of the sample had scores which signified ongoing PTSD [T2: 64% (n=12) and T3: 68% (n=13)]. At the end of the intervention there was some evidence for a reduction in alcohol use, but no evidence for drug use reduction. This may be reflective of the high numbers of women reporting abstinence in the past 30 days at baseline (58%) and the sample being under-powered to detect small changes.

The improvements captured quantitatively cannot be attributed to participation in the group due to the absence of a study control group. However, the qualitative data provided alternative

evidence: women described improved emotional wellbeing and those experiencing clinically meaningful change in the PTSD measure, described decreased PTSD symptoms such as flashbacks, nightmares, irritability and exaggerated self-blame, which they attributed to participating in the group. Women attending six sessions or more (defined as the minimal group dose in the study protocol) attributed improved wellbeing to skills developed in the group for managing emotions, particularly the grounding techniques taught in one of the topics, as well as the sensory-based activities delivered in the new component. They also described themselves as having improved self-esteem and adopting greater self-compassion, which was used to re-frame negative thoughts, interrupting the negative self-talk previously reinforced by experiences of IPA from a young age. Skills taught in the interpersonal topics related to asserting boundaries were evidenced in women's description of managing relationships with others. Whilst women provided less qualitative evidence in relation to substance use changes, the group resulted in women having greater self-understanding about the role of trauma in their substance use which some described as supporting reductions in substance use or abstinence. Evidence of the relationship between improved coping skills and emotional wellbeing were supported by the statistical analysis illustrating a correlation between high scores on coping skills and low scores on PTSD. Negative impacts of the group were experienced by a few women who described worsening PTSD symptoms whilst doing the group, due to the emotional intensity, or worsening relationships with family responsible for their child-hood abuse. However, some of these same women also improved in their PTSD symptoms at one or both follow up time-points and were thankful for taking part in the group.

The qualitative data were also able to allude to important contextual factors impacting on women's recovery. Individual factors related to the concept of 'readiness' and the ongoing challenges of co-occurring mental health problems, particularly depression, which interfered with women's ability to learn and practice coping skills learnt in the group. The quantitative data also demonstrated a correlation between high scores of depression and PTSD. External factors related to the wider service environment. Particularly the loss of substance specific and social support women experienced from the service closure, which contributed towards return to active substance use by some. There were wide variations in wrap-around services received by



individuals, including services provided via the study treatment service such as key-work and counselling, and those accessed elsewhere, such as 12-step groups. Women described a symbiotic relationship between these services and Seeking Safety; each re-enforcing coping skills learnt elsewhere. The inconsistent access to key-work and one-to-one counselling experienced by some women were unhelpful aspects of the wider service environment; but needed due to the emotional intensity of the group. Other external contextual factors of importance were the ongoing IPA experienced by women during the study; new incidents were recorded for 47% and 37% of women at T2 and T3 follow-up, respectively, and the descriptive statistics suggested that these women experienced less improvement in PTSD, compared to women experiencing no new abuse. Although this was not supported in statistical tests, this may be down to small sample sizes.

## Chapter 9: Discussion

### 9.1 Introduction

The overall aim of this PhD study was to determine the feasibility of delivering and evaluating an integrated trauma-specific intervention within routine substance use treatment in England. Phase 1 identified the evidence base, phase 2 explored stakeholder experiences of delivering trauma-specific interventions in England and the USA, and phase 3 reviewed and adapted Seeking Safety to evaluate the feasibility of its delivery (phase 4).

In the context of limited TIP in England, stakeholders who worked in services spanning a range of sectors in England were interviewed (Chapter 4); they were purposively selected for their delivery of integrated practice to address the co-occurring issues of IPA, PTSD and substance use among women. These stakeholders highlighted the extensive time required to focus on clients' safety and stabilization, due to the complex interplay of PTSD symptoms with substance use and IPA. This 'present-focused' work often took place over months and years before 'past-focused' trauma-specific interventions involving the revisiting of trauma memories, could take place. Some of these practitioners had delivered both present- and past-focused trauma-specific interventions, however, none of the interventions used had undergone robust evaluation, and the systematic review (Chapter 3) identified that no controlled trials of such interventions had previously taken place in the UK. The systematic review concluded that 'present-focused' integrated PTSD and substance use interventions may be particularly useful for women with more severe PTSD and substance use symptoms, or for those experiencing ongoing victimization. This was due to the extensive teaching of coping skills to promote external safety and symptom stabilization; which should be combined with access to safe social support and active case management. This aligned with the recommendations for a safety-first approach espoused by the stakeholders in England. The review suggested that in countries where access to such treatments in the mental health system are lacking, substance use services are well placed to deliver such interventions, with appropriately skilled staff and organizational adoption of TIP.

Taking forward the findings of the systematic review in Chapter 3, a feasibility study of a trauma-specific intervention was undertaken (Chapters 6-8) in order to answer key uncertainties of delivering and evaluating an evidenced-based intervention from the USA, within routine substance use treatment practice in England (Arain et al., 2010, Eldridge et al., 2016; Leon et al., 2011). In particular, uncertainty existed about the relevance of content and material in terms of the suitability of language, treatment philosophy and cultural references, and the level of training and supervision required to ensure practitioners can deliver the intervention with the required fidelity. Other key uncertainties involved: the ability to recruit sufficient women meeting the proposed eligibility criteria and to retain them in the study, due to the low numbers of women in substance use treatment in comparison to men (PHE, 2018); and the potential acceptability of the intervention model by participants and facilitators. In addition, consideration needed to be given to the particular challenges in providing psychological interventions to survivors of recent intimate partner violence who may not be ready to undergo psychological work (Warshaw et al., 2013). This latter point created uncertainty as to whether this group could be recruited and retained in the study safely, and whether the wider service delivery environment had the necessary wrap-around services to support them.

When choosing an intervention for implementation, the main considerations focused on the evidence base (Chapter 3) and appropriate fit with service delivery models in community-based substance use treatment services in England (Chapter 4). For example, the lower cost of group-work and requirements for staff skills and training compared to individual-based work. This represented an important consideration in light of the current fiscal climate which has seen ongoing cuts to addictions services over the past decade in England due to the devolvement of public health spending to local government and the removal of ring-fenced budgets (ACMD, 2017; Buck, 2016; Drummond, Day, & Strang, 2017). In addition, the systematic review (Chapter 3) identified that most of the trials of present-focused integrated interventions were delivered in group-work format, within publicly funded treatment services in the USA. The group-based models with the strongest evidence base comprised Seeking Safety and TREM. Interviews with US stakeholders (Chapter 4), with substantial experience of delivering both Seeking Safety and TREM models, highlighted strengths and weaknesses for both. Importantly for feasibility

considerations, they stressed that these interventions did not require delivery by highly-qualified psychology practitioners.

The interviews with US stakeholders identified that on-balance Seeking Safety was more appropriate for women less advanced in their recovery from substance use and for those with more recent experiences of IPA. This model also afforded flexibility in adaptation for local treatment settings, in terms of selection and number and order of topics, lending itself to fit with the length of typical group-work programmes offered in community-based substance use services in England, as well as the standard 12-session PTSD treatments promoted by NICE between 2005-2018 (NICE, 2005). The Theory of Behaviour Change guided the selection of topics (Chapter 5), reducing the number of Seeking Safety sessions from 25 to 12, and further adaptations were also made such as the addition of mind-body activities.

Guided by the study design of the largest and most robust trial of Seeking Safety published (Hien et al., 2009), the feasibility study (Chapters 6-8) involved two cycles of an adapted Seeking Safety group-work intervention, comprising 12-sessions each delivered over 6 weeks. The study substance use treatment service was chosen for its track-record of offering gender-specific services to women, and its work towards TIP. The findings from this phase of the study (Chapters 7-8), using a mixed-methods single-group design, were considered in terms of: 1) acceptability to facilitators and participants, 2) evidence for the feasibility of key study parameters, and 3) important contextual factors which impacted the success of the intervention.

This chapter draws together the learning from all study phases to discuss: 1) the implementation considerations for substance use services wishing to adopt integrated trauma-specific group-work treatment models and 2) additional considerations for future feasibility studies of the Seeking Safety model. The chapter will conclude with key recommendations for practice, policy and research.

## **9.2 Implementation considerations**

An important part of the diffusion of a new intervention into service delivery (Roger, 1995) is that the target audience, including the staff tasked with delivering the intervention, perceive its acceptability and feasibility, in relation to the relevance, utility, and relative advantage over other interventions, along with its compatibility with service delivery models (Brown et al., 2007; Killeen, Back, & Brady, 2015; Rogers, 1995). These issues are discussed below in terms of the content, process, and format of the adapted Seeking Safety intervention. Furthermore, the championing of integrated trauma-specific interventions, such as Seeking Safety, must be considered in the wider context of commissioning and budget constraints facing public health services in England, another facet of compatibility which influences the adoption of new innovations (Rogers, 1995).

### **9.2.1 Relevance and utility of Seeking Safety content**

#### **9.2.1.1 Core role of copings skills to manage emotional regulation**

The key individual behaviour change targeted in the conceptualisation of the intervention (Chapter 5, Figure 10) was the adoption of more healthier coping strategies to replace substance use and manage PTSD symptoms. The systematic review suggested this emphasis on coping skills was a core mechanism of change for present-focused interventions. As highlighted by the utilisation of the COM-B framework for reviewing the Seeking Safety intervention (Chapter 5, Appendix 15), experimenting with strategies to tolerate cravings and manage PTSD symptoms, combined with the belief that the new strategies can work, are pre-cursors to adopting behaviour change and linked to the promotion of self-efficacy. Understood as the ability to connect to one's innate abilities and capabilities, self-efficacy is believed to play a significant role in behaviour change, including desistance from substance use (Cummings, Gallop & Greenfield, 2010; Miller & Rollnick, 2002; Trucco, Connery, Griffin, & Greenfield, 2007). Self-efficacy may also be linked to feelings of control over recovery from IPA, which has been implicated in reduced PTSD among sexual assault survivors (Walsh & Bruce, 2011).

Although most women participating in the feasibility study experienced the subject matter as intense, the topic content was viewed as highly relevant, with high mean evaluation scores for all

topics delivered. The comprehensive focus on the wide-ranging impacts of IPA such as anger, low self-esteem, lack of self-compassion, and difficulties with boundaries, were not only relatable but touched core parts of their being. The systematic review identified that the trial literature was less illustrative of the *type* of coping skills women found most useful, and their differential impact on the different symptom clusters or external stressors. In the feasibility study, the move towards more active coping was evident in the narratives of women who discussed using the skills of mindfulness, acceptance of emotions, grounding techniques and moderation of cognitive appraisals to lessen the impact of heightened states of emotional distress. Although the statistical results from this study should be interpreted cautiously, due to constraints in the study design (see limitations section 9.5.6), on average the group did experience improved emotional regulation and reduced PTSD symptoms; low PTSD was also highly correlated with greater coping skills at both follow-up time points. This may be due to the increased use of positive emotional regulation strategies, which replaced other common strategies such as rumination (recurrent thoughts focused on negative emotions) and emotional suppression, implicated with more severe PTSD symptoms (Chesney & Gordon, 2016; McClean & Foa, 2017). The statistical analysis in the feasibility study precluded attempts to explore causal pathways between PTSD, substance use, and emotional regulation. However, the systematic review highlighted how emotional regulation is implicated in the causal pathway between PTSD and substance use (Tull, et al., 2015). Changes in emotional regulation have also been found to moderate the efficacy of prolonged exposure on PTSD and substance use outcomes (Hien et al., 2017).

Given the potential of emotional regulation as a ‘trans-diagnostic’ treatment target (Sloan et al., 2017), improvements in this domain may explain the improvements identified in depression symptoms among the study participants, which were highly correlated with PTSD at both follow-up points. Women identified how ongoing depression impeded their ability to implement the new coping skills learnt in the study, a barrier also highlighted by women in other studies of trauma-specific interventions (Harris et al., 2005). This re-iterates the importance of targeting both mental health conditions among women with experience of IPA. A recent meta-analysis of group-work for people with signs of Complex PTSD suggested that the psycho-education found in present-

focused interventions is particularly beneficial for alleviating more general distress experienced by survivors of IPA, such as anxiety and depression (Mahoney, Karatzias, & Hutton, 2019).

#### **9.2.1.2 Coping skills to address anger**

The emotion of anger appeared frequently in the dialogue with participants, the facilitators and the service manager of the study treatment service. The session topic *Healing from Anger* was cited by women as being particularly helpful, and needing more session time, perhaps indicative of the importance of this emotion in treatment for women with histories of IPA and substance use, and the lack of appropriate attention provided by other substance use interventions. Anger is one of the symptoms of PTSD and those with PTSD have been found to have greater anger difficulties than those with other the anxiety disorders (Olatunji, Ciesielski & Tolin, 2010), which may be explained by the 'emotional injustice' felt by survivors of IPA (Chemaly, 2018). In the feasibility study, women reported high levels of childhood abuse; in other research, survivors of childhood abuse have demonstrated higher levels of anger compared to those experiencing IPA in adulthood (Pelcovitz et al., 1997).

To assert anger is transgressive of female norms and represents recognition that one has been wronged and that fundamental changes are required (Chemaly, 2018). These feelings, cumulated through multiple and repeated IPA across the life-time, may contribute towards women's own use of violence in response to further abuse by intimate partners (Swan & Snow, 2002; Walker, 2013). Rather than conceptualise anger as part of individual pathology, it is important to contextualise this anger within the wider societal structures that permit the continued occurrence of IPA directed at women, and a treatment system that is not yet sufficiently structured to respond adequately (Marsh, D'Aunno & Smith 2000; Nelso-Zlupko, Kaufman & Dore, 1995; Simpson & McNulty, 2008). Stakeholders from England, working in specialist services for women who have experienced IPA, also stressed the importance of contextualising women's experience of IPA as a societal problem. Facilitators in the feasibility study provided psycho-education to help contextualise women's individual experiences of abuse within this wider system, helping to shift the re-attribution of blame of the abuse clearly onto the abuser, whilst discussing safe and healthy ways to express anger. The value of this was evidenced in the qualitative interviews with

participants who came to new realisations that they were not to blame for the abuse. I argue this approach also serves as an importance antecedent and strategy for women to address issues of anger and provides the foundations for using the individual behavioural skills taught in the Seeking Safety intervention. This approach fits within the socio-ecological model of understanding IPA (Chapter 1), which underpins this study and stresses the individual, relationship, community, and societal influences contributing to IPA victimisation (and perpetration) and how the mental health impacts are experienced (Campbell, Dworkin, & Cabral, 2009; Heise 1998). The suppression of anger has been associated with 'drinking consequences' in women, described as problems with relationships and involvement in the criminal justice system as a result of drinking (Tivis, Parsons & Nixon, 1998). Therefore, the provision of skills to express anger in more healthy ways may result in reduced alcohol (or other drug) use over time.

#### **9.2.1.3 Coping skills to enhance the mind-body connection**

The systematic review identified one trial whose active component focused on the mind-body connection, however, this focus was clearly valued by women (Price et al., 2012a) and may be useful for particular PTSD symptoms, such as dissociation. Many of the stakeholders interviewed from England (Chapter 4) worked in services that offered mindfulness and alternative therapies as part of their standard service. Several of the US stakeholders also positively endorsed this practice response. Participants in the feasibility study also spoke to the effectiveness of coping skills focused on the mind-body connection, frequently mentioned as the most helpful parts of the intervention, with illustrations of how they were successfully used to regulate emotions and manage other PTSD symptoms. Since interventions such as Seeking Safety were first developed there have been vast developments in understanding the neurobiological and physiological impacts of trauma (Rothschild, 2000; Levine, 2010; van der Kolk, 2014). These developments have led researchers to argue for strategies that help balance the 'emotional' and 'rationale parts of the brain' (van der Kolk, 2014). Whilst Seeking Safety includes a whole topic on grounding techniques, including physical strategies, the intervention review phase (Chapter 5) identified the need for more activities reliant on the mind-body connection as tools for self-soothing. As a result, the new components introduced to Seeking Safety invited women to make up a 'comfort kit', based around the five senses; and the use of an 'ending ritual', using a fragrant spray to ensure



women were brought back into balanced states of arousal before leaving the room. Women provided tangible illustrations of how the introduction of these skills in their daily lives helped them to feel better, feel more in control and cope with life stressors in a healthier manner compared to before. The reason for these improvements is best understood within the concept of the 'Window of Tolerance' (Ogden & Minton, 2000; Siegel, 1999) which is conceived as an optimal level of arousal functioning. Figure 25 outlines the states of being related to PTSD that are associated with being outside this window (hyper-arousal and hypo-arousal) and illustrates how being in the 'Window of Tolerance' then allows for better cognitive functioning.

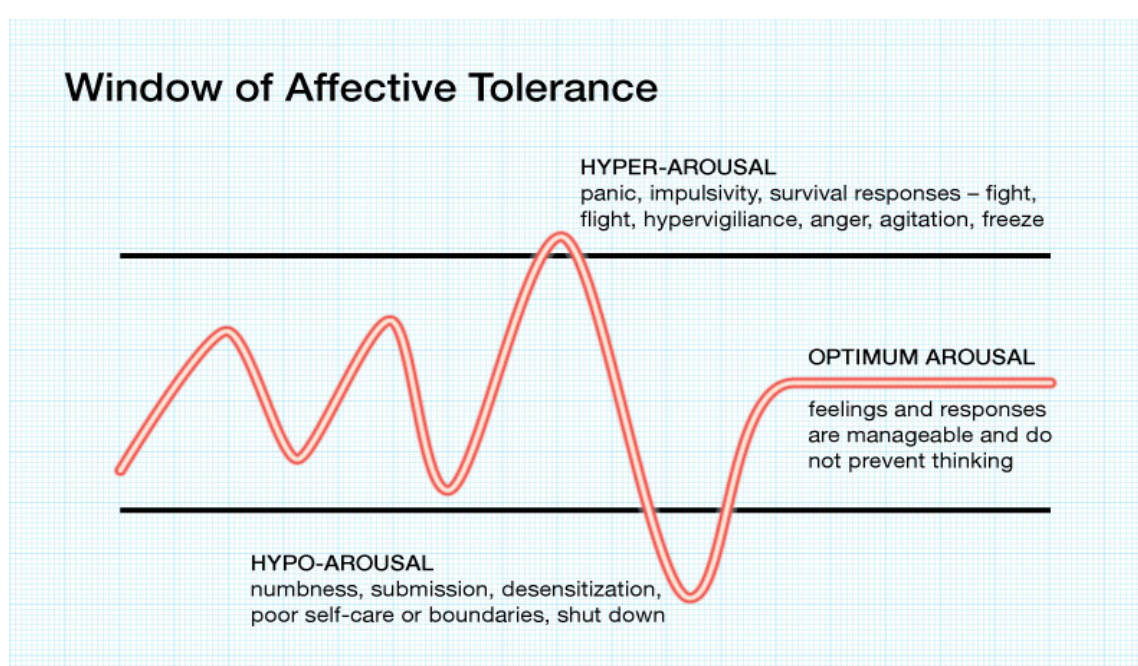


Figure 25: The Window of Affective Tolerance  
(adapted from Siegel, 1999)

When people are vacillating between extreme states of hyper- and hypo –arousal, it is extremely challenging to distinguish these states of being and associated thoughts from past trauma. People with PTSD are operating on sensory overload; the part of the brain responsible for concentration, attention and learning has been compromised by the trauma. It thus makes it difficult to undertake any cognitive work that involves analysing and planning (van der Kolk, 2005). This is where the role of sensory techniques of 'grounding' are vital. Participants in this study described the clenching of fists, touching of a feather, smell of lavender oil on a scarf as techniques that helped

them to cope. They were reaching out to the tools and strategies that felt most accessible in times of too much physical arousal (which they described differently as stress, anxiety, panic attacks, distress, anger, irritability), and using them to bring them back into their 'Window of Tolerance'.

Women also described developing a greater tolerance to sit with their emotions and non-reactiveness, which they associated with the use of the grounding techniques. The concept of mindfulness is not one that is directly discussed in Seeking Safety or 'taught' as a distinct coping skill, perhaps because it is a treatment approach that has developed within the substance use treatment community only since the Seeking Safety manual was published. However, the 'de-coupling' from emotions are important early coping skills, particularly in the treatment of more Complex forms of PTSD (Kelly & Garland 2016; van der Kolk, 2014). As outlined in the systematic review (chapter 3), there is mounting evidence for the usefulness of mindfulness-based practices such as yoga and meditation for addressing PTSD (Emerson, 2014; Goldsmith et al., 2014) and substance use (Li et al., 2017) separately. But one can posit how this treatment approach would be useful in targeting both issues. It is the development of this new relationship with one's emotions and uncomfortable sensations which may reduce reactivity to substance-related cues (Li et al., 2017). Enhancing the body's capability systems responsible for managing arousal and inducing the para-sympathetic system may enhance the capabilities of cognitive re-appraisal, by supporting detachment from feelings such as guilt and blame (Dick, Niles, Street, DiMartino, & Mitchell, 2014; Goldsmith et al., 2014; Kelly & Rowland 2015), which may also ultimately reduce substance use (Luoma et al., 2012).

Therefore, the inclusion of more mindfulness-orientated activities, and sensory-based coping skills into the Seeking Safety intervention, are key recommendations for future implementation, and skills that can be both adopted and taught by substance use practitioners, without additional training or specialist expertise. This would serve to strengthen the activities and coping skills already present in the intervention such as those found in the *Grounding* and *Self-nurture* topics. Practicing these techniques routinely before embarking on the main topic content, would appear extremely important to help women maintain their 'Window of Tolerance'. This may be all the

more important for those still in active substance use and/or those managing extreme emotional regulation states.

#### **9.2.1.4 Reframing negative thinking using compassion**

Some women, particularly those in Group 1, described the assimilation of more cognitive-based strategies for managing their distress. Substance use abstinence at baseline was reported by more women in Group 1 compared to those in Group 2, and whilst it remains a hypothesis, one could propose that the adoption of more cognitive-based strategies in this group was reflective of women being in a better 'head-space' when starting the group, a point also suggested by some participants themselves.

Several topics in the intervention involved exercises akin to aspects of cognitive restructuring, a common treatment for PTSD (Mueser, Rosenberg, & Rosenberg, 2009). Women were asked to identify their negative self-talk and self-evaluations, explore where these may have come from in relation to IPA, and re-frame more compassionately. Compassion in its integral sense means connecting with the suffering of oneself and others and committing to alleviate this suffering (Dalai Lama, 2001). Women offered up evidence that they learnt to stop blaming themselves for the abuse, chastising themselves for the way they look, and were able to evaluate their past actions less critically. They linked these changes to reports of feeling better, improved self-esteem, and in some cases avoiding the resort to drink or use other substances. In other research among sexual assault survivors, negative beliefs about role of self in the assault and negative societal reactions to the assault differentiated survivors with PTSD and problem drinking from those with PTSD only (Ullman, Filipas, Townsend, & Starzynski, 2006), suggesting the importance of targeting self-blame for reducing substance use among survivors of IPA. Self-criticism has also been identified as an important treatment target across a number of mental health conditions (Castilho, Pinto-Gouveia, & Duarte, 2017; Cuppage, Baird, Gibson, Booth, & Harvey, 2018). Other qualitative research identified that women's adoption of loving and forgiving attitudes towards themselves had replaced their anger and resentment towards life and were key to recovery following completion of integrated trauma-specific group-work interventions (Harris et al., 2015).

Cognitive restructuring involves the articulation of thoughts that underlie distressing emotions and then weighing up the evidence for those thoughts, with a view of moderating them (Mueser et al., 2009). This may also be linked to improved emotional regulation. In one trial of CBT for PTSD among people with severe mental illness, participants who received the additional components of cognitive restructuring, in addition to breathing and psycho-education about PTSD, showed improved treatment effects (Mueser et al., 2015). A trial of trauma-focused CBT, a combination of CBT and trauma memory processing treatment, demonstrated that reduction in negative trauma appraisals mediated PTSD improvements (Kleim et al., 2013). Interestingly, participants receiving the trauma-focused CBT showed steep declines in negative appraisals early on after the first session, which focuses on psycho-education about PTSD to help participants understand their experiences. The authors suggest that this 'normalisation' of symptoms already played a role in helping people to re-evaluate themselves as being 'mad' or 'crazy' because of their PTSD symptoms (Kleim et al., 2013). Similarly, others have argued the importance of targeting negative core-beliefs (e.g., one cannot control the threat of disaster) among those in treatment for opiate and alcohol use (Brotchie, Meyer, Copello, Kidney, & Waller, 2004). If such cognitive strategies have been found to be crucial for PTSD symptom improvement in other forms of PTSD treatment, and are important targets for substance use treatment, it is reasonable to assume they may be active ingredients in Seeking Safety in terms of reducing PTSD symptoms, and potentially substance use.

Advocates of 'woman-centred' addiction treatment cite the importance of helping women put their experiences related to addiction and mental health in a social context, so they learn not to see all their problems as a facet of individual dysfunctional pathology (Covington, 2000). As with anger, the contextualisation of thoughts, feelings, and actions within the wider ecological model of IPA is an important component of self-compassion and for reframing negative trauma appraisals. This conclusion re-iterates the importance of the treatment staff and wider service adopting a philosophical approach, which positions IPA and substance use beyond individual pathology, cited by stakeholders in England (Chapter 4) and noted in the model of behaviour change underpinning in this study (Chapter 5, Figure 10).

### **9.2.2 Seeking Safety format**

Overall there was strong support for the structured nature of the group and limited criticism about any of the main components such as check-in/out, hand-outs and the out-of-session work (the 'commitments') among the participants. In-fact despite the ongoing concerns by the facilitators about asking women to sign up to 'commitments', this component appeared to be a valued and important BCT for many. For some, the structured nature of the group format, combined with the topic matter, was precisely what gave it relative advantage over other interventions. 'Keeping a tight ship' to ensure sufficient discussion about the meaningful topic matter and the requisite coping skills was important.

However, a repetitive theme in the qualitative interviews was the notion of insufficient time and inadequate pace during the sessions; it re-occurred in relation to women feeling able to express themselves, ability to absorb the material and reading through the hand-outs. This was also corroborated by the group facilitators. It suggests that the intervention as it was delivered in this study was too condensed. Implementation guidance for Seeking Safety provides tremendous flexibility to design the intervention to best fit the needs of the treatment service and clients. This was one of the motivating factors for selecting the intervention over and above others. Therefore, the choice to contain one topic to one session and deliver 12-sessions was a factor of study design; enabling compatibility with typical group-work length in substance use treatment and aiming to promote higher study retention. This was informed by the systematic review, which identified heterogeneity amongst trials of Seeking Safety, in terms of the number of sessions delivered (range 6-25), but suggested shorter treatments may be superior for treatment retention ( e.g see Amaro, Chernoff et al., 2007 and Myers et al., 2015). In the largest trial of Seeking Safety, which involved 353 women, the decision to deliver 12-sessions over 6 weeks was seen as the most pragmatic in order to recruit and retain sufficient women (Hien, Cohen, & Campbell, 2009). A robust meta-analysis suggested that full dose Seeking Safety did not have an advantage over a 12-session dose in post-treatment PTSD outcomes, but did evidence drug and alcohol reduction not seen in the shorter version (Roberts et al., 2016). Results from this feasibility supports this: whilst there was some evidence for reduced alcohol use, this was not the case for

drug use, which may have been due to the high numbers of women reporting abstinence at baseline (58%) but is also testimony that entrenched substance use may be harder to treat than PTSD in time-limited interventions (Najavits & Hien, 2013).

Participants in the study recommended offering a longer intervention, a recommendation found elsewhere in other sites implementing Seeking Safety (Brown et al., 2007), and also testimony to its acceptability and perceived relevance. The need for longer treatments beyond those typically found in evidenced-based PTSD treatments, was also a key finding from the systematic review, and echoed by stakeholders from England supporting women with co-occurring issues. Furthermore, new NICE guidance for PTSD treatment acknowledges the need to extend interventions beyond standard 12-sessions for those with more complex PTSD symptoms and with co-occurring mental health issues (NICE, 2018, p21). A lengthier group, and splitting topic content, would be one way of 'slowing down the pace' and accommodating new elements, and is allowed within the intervention implementation guidance (Najavits, 2002).

Correspondence with a clinician who also recently piloted the Seeking Safety model within a Women's Centre in England recommended the development of a preparation group for women who are less stable in their substance use or other lifestyle factors (e.g., homelessness) (Dr E. Haddock, personal communication, 2 August 2017). This supports the recommendation from one of the group facilitators in this study who suggested offering a lengthier 'pre-orientation' to allow women to become familiar with the structure of the group and establish basic principles around physical and emotional safety. This group could place greater emphasis on crisis management and emotional regulation strategies.

### **9.2.3 Seeking Safety process**

#### **9.2.3.1 Group cohesion and therapeutic alliance**

In this study, the complexity of the group dynamic and participant-facilitator alliance were highly influential on the acceptability of the Seeking Safety intervention for both the study participants and the facilitators. The systematic review highlighted how attention must be paid to the wider contextual/relational aspects of therapy, such as therapeutic alliance and therapist empathy, which may be more important to positive client outcomes than the technique used (Godlaski, Butler, Heron, Debord, & Cauvin, 2010; Greenberg, 2016; Najavits, 1994; Stiles et al., 1998). This is supported by repeated meta-analyses which identify that client-therapist/facilitator alliance is related to positive outcomes in psychological therapy (Flückiger et al., 2018; Horvath, Del Re, Flückiger, & Symonds, 2011). Another meta-analysis of 55 studies, involving interventions for a range of psychological interventions, concluded that there was a strong link between group cohesion and positive therapeutic outcomes, albeit with large variance across studies (Burlingame, McClendon, & Yang, 2018). None of the trials in the systematic review measured group cohesion, however one trial explored the relation with therapeutic alliance between client and therapist for Seeking Safety (Ruglass et al., 2012); demonstrating that regardless of treatment or control, women who showed early therapeutic alliance (after week 1, 2-sessions) also experienced better retention and PTSD outcomes, but not substance use outcomes.

The participants in this study, attending the minimal dose exposure, scored higher therapeutic alliance, with both facilitators, compared to women attending less than six sessions; suggesting that therapeutic alliance may be implicated in study retention and/or strengthen over time. The qualitative interview data confirms this, with some women's alliance with the facilitators changing from negative to positive over the course of the intervention, as they became more familiar with the structure of the group format and facilitator styles. A recent meta-analysis of 295 psychological therapy studies found that the measures of therapeutic alliance were more highly correlated with outcomes when they were assessed later on in therapy (Flückiger et al., 2018). This supports the need to measure therapeutic alliance at the end of treatment.

Factors related to group cohesion were aspects of the intervention cited as most and least helpful by the participants, more so than facilitator alliance, and the continual struggles to manage the group dynamic concerned the facilitators throughout the study. The dominance of these themes in the qualitative data reinforces the centrality of relationships in women's healing from IPA, PTSD, and substance use; particularly for survivors of childhood abuse and intimate partner violence for whom safety and security in relationships have been ruptured (Briere, 1992; Cloitre et al., 2004; Herman, 2001; van der Kolk et al., 2005, van der Kolk, 2014). Proponents of women-only substance use treatment also cite the importance of relational modes of working which place value on the interactions with others as a channel for promoting healing and recovery (Covington & Surrey, 1997; Grella, 2008), and are also described as foundational components of many trauma-specific treatments delivered in a group format (Covington & Bloom, 2007; Harris & Fallot, 2004;). This was also a theme in the interviews with stakeholders in England in terms of the philosophical approach driving service delivery for women (Chapter 4).

Whilst some participants in the feasibility study extolled the virtue of being with women with similar experiences, a 'them and us' mentality evolved between women in different stages of substance use recovery; this finding serves as a reminder that women in groups are heterogenous and diverse (Neale, Nettleton, &, Pickering, 2014; Neale, Tompkins, Marshall, Treloar, & Strang, 2018). The quantitative measure of group cohesion found this to be the case in both Group 1 and Group 2 indicating that this problem continued despite the facilitators being more familiar with the material in the delivery of the second group. These factors have been identified previously in other studies of women-only treatment (Godlaski et al., 2009; Neale et al., 2018) highlighting that some of the challenges faced in mixed-gender groups cannot be fully eradicated in women-only groups.

In order to enhance group cohesion, researchers have recommended paying attention to activities which encourage interaction between members, positive emotional and working relationships, and addressing conflict (Burlingame et al., 2018). Another recent study, focused on a trial of gender-responsive treatment for women in substance use treatment, found that women receiving more positive affiliations statements from other group members experienced greater reductions in substance use following the end of the intervention (three months), which was sustained at the



six months post-treatment phrase (Valeri et al., 2018). Statements included ones of agreement, support, advice to others, and engaging questions. Average numbers of affiliative statements were also higher in the gender-responsive treatment compared to the mixed-gender treatment as usual. This is an interesting method of measuring group bond and interaction, and the authors recommend that the promotion of affiliative interaction by therapists may partly explain the therapist-outcome relationship and thus a potential mechanism of action (Valeri et al., 2018).

The qualitative data identified that these activities were indeed promoted by the facilitators; encouraging interaction between peers and facilitating positive emotional and working relationships between women. Participants also scored highly the group cohesion subscale relating to feeling accepted and respected by the group and helpfulness of other members. Whilst some authors have suggested that not all women want single-gender treatment (Neale et al., 2018), this was an important facet of the intervention format for women in this study given the focus of the group was on IPA, most often perpetrated by men. Women described being empowered from being in the presence of other women with shared experiences of IPA; hearing their struggles and experiences of overcoming these. This in turn helped women to feel 'more normal', improving emotional well-being, and for some women, directly supporting abstinence. The use of single-gender groups as a vehicle to promoting recovery in these ways has been identified in numerous other research studies with women in treatment for a variety of mental health, inter-personal issues, and substance use (Brown et al., 2007; Covington & Surrey, 1997; Harris et al., 2005; Greenfield, Cummings, Kuper, Wigerson, & Koro-Ljuunberg, 2013; Grella, 2008; Messina, Calhoun, & Warda, 2012; Moses & D'Ambrosio, 2004; Walker et al., 2013).

Study participants provided the highest ratings of group cohesion in those subscales relating to investment in the therapy; agreement that the intervention content was the best way to treat their problems and was worthwhile. Therefore, despite the identified negative aspects of the group dynamic, the group format would appear to provide a crucial active ingredient in facilitating mechanisms that supported recovery. However, both cycles of the groups would have benefited from slowing down the pace of the sessions and removing the rigid focus on adherence to all aspects of the intervention content, in favour of the group process. This would have allowed the

facilitators to attend to group conflict, promote more sharing of stories and views, and consequently more positive affiliative statements suggested by Valeri and colleagues (2018), and would ensure women felt their voices were heard; potentially building on the positive mental health outcomes that women reported at follow-up. This is discussed further in the next section.

### **9.2.3.2 Enhancing group cohesion and facilitator alliance**

One of the over-arching critiques by the facilitators in this study was their inability to focus on the therapeutic aspects of the group alliance which left them feeling anxious, 'dangling over a cliff-edge', concerned for the emotional safety of some participants. This was due to the pressures to deliver other content components of the intervention within the short session time-frame, which may also have contributed towards the perception of one facilitator as being 'strict' or 'school-like'. The facilitators' concerns were undoubtedly exacerbated by undergoing assessment of their adherence to the fidelity of the intervention. Research suggests that therapeutic alliance should be prioritised over and above strict adherence to the fidelity of the intervention. In a sub-sample of 121 study participants (30% women) involved in a trial for the treatment of cocaine dependence, therapist alliance interacted with adherence to indicate that where alliance was strong, people had better outcomes regardless of adherence, but this was not the case where client-therapist alliance was weak (Barber et al., 2006). Moreover, researchers found that intermediate adherence was most optimal for successful reductions in substance use and depressive symptoms. They theorised that this could be because very high levels indicate a lack of flexibility and client responsiveness and low levels reflect the inability to translate key active mechanisms into the treatment delivery (Barber et al., 2006). Others have argued, similarly, that the trouble with 'packaged' or highly structured manuals used in treatment interventions is they focus attention away from relationship in favour of technique (Day & Mitcheson, 2017; Marshall, 2009; Orford, 2008). This suggests that adequate adherence to the intervention should allow group facilitators to deviate from the manual when it is deemed necessary to promote therapeutic alliance and group cohesion. This study also suggests that allowing greater flexibility in manual adherence would have better supported facilitator acceptance, an important facet for the diffusion of integrated trauma-specific interventions into community substance use treatment settings (Killeen et al., 2011).

The Seeking Safety implementation guidance (Najavits, 2002) contains the boundaries for ensuring safety in the group process, which are assessed as part of the fidelity monitoring. When women attempt to express details of their own traumas, facilitator responses should validate what someone has said, explain why it may not be safe to explore in more detail in the group, and offer follow-up support. Similarly, in order to keep check-in short, facilitators are encouraged to guide women gently back to the focus of the questions and explain that they will return to pertinent issues disclosed later in the session. Follow-up conversations should focus on those women disclosing unsafe behaviour such as substance use or risk mental health states in the check-in. The facilitators struggled with becoming fluent in this aspect of the intervention, which may explain why women described feeling 'cut-off' or 'shut-down'. However, these are important safety boundaries that are the bedrock of the intervention and should remain the focus of adherence. In both the focus groups, there was overall support for limiting the discussion of trauma narratives, with one exception; one woman, who had been abstinent six months, was hoping to explore her trauma in detail, perhaps indicating a readiness for second stage treatment such as narrative exposure (e.g., Ehlers et al., 2005; Foa, Hembree, & Rothbaum, 2007). Whilst experts agree that not all those with PTSD require systematic confrontation with trauma memories in order to recover (Ehlers et al., 2010), greater relief is gained from PTSD symptoms through exposure work combined with CBT compared to CBT alone for those able to tolerate them e.g., those in more stable and safe environments (Ehlers et al., 2013; Mills, Teeson et al., 2012; Sannibale et al., 2013).

The Seeking Safety implementation guidance allowed women to return to the group after missed sessions; in the study this was allowed as long as women did not miss more than three sessions without making any contact with the service. The facilitators and those participants with more consistent attendance found this unhelpful, describing the negative impact this had on the group cohesion. Both facilitators and participants suggested assessing for readiness or motivation to take part in assessment of eligibility, to support better retention. There are some questionnaires available to do this e.g., Group Selection Questionnaire (Davies, Seamam, Burlingame, & Layne, 2002; Krogel, Beecher, Presnell, Burlingame, & Simonsen, 2009). However, how these may be used in practice is questionable; for example, determining the cut-off point for rejecting someone

and justifying that decision within TIP, particularly when rejection from services and low self-worth are the hallmarks of many women with co-occurring issues. Refusing continued attendance to women who miss sessions is also contrary to the flexibility required by TIP, and in direct conflict with the good practice cited by stakeholders interviewed in Chapter 5. Therefore, services may wish to consider imposing a limit to the number of consecutive sessions missed, agreed by the group in a collaborative manner as part of the group-agreements, with the proviso that women who exceed this limit are actively encouraged to join the next group cycle.

The concept of 'readiness' also highlights the importance of providing access to trauma-specific interventions on a regular basis and allowing women the flexibility to re-join new groups when they are ready, and however many times they like. Two women who dropped out of Group 1 did not attend the pre-orientation session with the other women. For both women, this resulted in them feeling separated from the group when they attended the first session. Although other studies of Seeking Safety have suggested that offering open enrolment supported group retention (Hien, Cohen et al., 2009), the findings from this study suggests maintaining closed groups is important aspect of acceptability for both the participants and facilitators.

#### **9.2.3.3 Supporting facilitators towards adequate intervention adherence**

In other studies of Seeking Safety, 60% of clinicians reported feeling comfortable with delivering the intervention within one month (Brown et al., 2007). In this study, the facilitators were not comfortable delivering the intervention by the end of the two groups (12 weeks). Some of this may have been mitigated with the suggested adaptations to the group described above, as implementation guidance does promote flexibility:

“...despite its highly structured approach, the treatment is designed to adapt flexibly to therapist preferences. For example, some therapists enjoy using CBT forms in sessions, while others dislike them; they are provided but always optional. Many topics have multiple subtopics from which to choose, and instead of a strict protocol various ways to address the material are suggested.” (Najavits, 2002, p.10-11)

However, the facilitators in this study were unsure which parts of this guidance and the hand-outs they should prioritise within the sessions, whilst observing other aspects of adherence such as

balance of client/participant talk, discussing both substance use and PTSD in each session, adequate focus on hand-outs, and maintaining the group cohesion and therapeutic alliance. This no doubt comes with experience of running the groups (Najavits, Kivlahan, & Kosten, 2011). However, this finding also highlights the crucial role of providing one-to-one supervision to new facilitators until they feel comfortable and proficient, something I was not qualified to do as part of the research study, despite undertaking some training. The implications for substance use treatment services are to ensure allocation of sufficient budget for the provision of training and supervision when starting out, by someone with experience of delivering these groups (Killeen et al., 2015). Training provided to support facilitators to become fully competent should include experiential exercises to practice techniques such as role-play, check-in, and responding to difficult scenarios (Najavits, 2004; L. Najavits, personal communication, 7 December 2017). The choice to provide initial online training to the facilitators in this study was a budgetary one, although later attempts to provide more experiential training was constrained by facilitator availability. However, Najavits (2004) also states that one of the most important areas of growth for both the supervisor as well as the facilitators is to understand the diversity of interpretation allowed in Seeking Safety. This skill is important in order to guard against the treatment protocol feeling too directive or judgemental, to both facilitators and group participants (Najavits, 2004 p.91), something that was apparent in this study but can be avoided by others.

Najavits also points out that openness to adopting manualised practice and proficiency in CBT interventions are important when selecting facilitators (Najavits, 2004). In this study, facilitators were selected on the basis of numerous interpersonal qualities such as commitment and passion, combined with their extensive experience working with women, and their combined substance use and PTSD expertise. These factors are crucial for working with traumatised women in substance use treatment, as identified in the systematic review (Covington & Bloom, 2007; Najavits, 2002, 2004; Marel et al., 2016; Markoff et al., 2005; Tompkins & Neale, 2016). However, training and experience in CBT treatments were not a requirement. Although one facilitator used CBT predominantly within her relapse prevention groups, it is unclear to what proficiency. The other facilitator, although certified in CBT, came from a psycho-dynamic background. Surveys with practitioners delivering psychological interventions have demonstrated that practitioners

experienced in CBT are more positive about manuals than those coming from a psycho-dynamic approach, and those with less experience in therapy are more positive than experienced practitioners (Addis & Krasnow, 2000; Lucock, Hall, & Noble, 2006). Therefore, the backgrounds of the study facilitators will have also influenced their responsiveness to adopting the more structured approach to intervention adherence, required in this study.

Whittington & Grey (2014) discuss the use of 'meta-competencies' when training CBT therapists, which have application to this study. These are defined as 'higher level' competencies which focus on the ability to implement structured manuals, such as Seeking Safety, in a manner which is flexible and tailored to the needs of the individuals (Roth & Pilling, 2007). The authors discern between: 1) principles (conceptual underpinning and core methods); 2) tactics (deciding how to set up methods for cognitive change or which problem to address first); and 3) techniques (e.g., reframing or behavioural experiments). When starting off therapists are guided to hold all aspects rigidly; as therapists become more experienced 'meta-competence' adherence allows for the appropriate adaption of techniques and tactics whilst holding the principles firmly, with diversion from manual guidance based on rationale and evidence base (Whittington & Grey, 2014, p.12). Therefore, when supervising and training group facilitators for Seeking Safety, attention should be paid to using the principle of meta-competence adherence in coaching and training.

In choosing which techniques to focus on, the findings with regard to BCTs evidenced by the study participants may also be useful (Michie et al., 2011; Michie et al., 2012; Orford, 2008), something that has not featured in previous studies of Seeking Safety. The results suggested that a hierarchy of BCTs were at play in the Seeking Safety intervention, in that certain BCTs were instrumental in facilitating others. Implementing techniques to support women to *reframe negative self-talk*, promote *self-identity*, *goal setting*, and 'ground' themselves would appear particularly relevant for reducing negative emotions, perhaps more so than other BCTs promoted in Seeking Safety such as *role-play and behavioural experiments*. Therefore, when faced with the array of techniques and handouts in each session, facilitators may be re-assured to know there are some key areas that could be prioritised over others.

As with the study participants, the facilitators also found delivering the intervention intense and emotional. Clinical supervision was funded by the study treatment service and was an important component for promoting self-care for the facilitators, and to prevent vicarious trauma (Cadiz et al., 2004; Heckman et al., 2005; Mills, Back et al., 2012; Moses et al., 2003; Moses & D'Ambrosio 2004; Tompkins & Neale, 2016). From a cost-benefit perspective, supervision has been found to reduce staff turnover among substance use treatment staff, an effect partially mediated by perceived occupational autonomy and well-being (Knudsen, Ducharme, Roman, 2008). In addition to this external support, greater involvement from the service manager was needed to ensure the facilitators were not isolated, and to provide day-to-day or weekly support in between clinical supervisions.

#### **9.2.4 Responding to context**

As discussed in the systematic review, increasing attention is being paid to wider contextual factors that shape how individuals may respond to an intervention. Factors external to the intervention, either the wider service or wider community “*can be enabling or disabling depending on the capacities they offer for...supporting behaviours beneficial for people’s health.*” (Weiss, 1997, p.10). The study results suggested that the wider support networks of women, including those provided by the study treatment service, as well as ongoing exposure to IPA require attention by treatment providers. Furthermore, it is in the wider context of commissioning and budget constraints that services must make the case for funding of new interventions and capitalise on policy drivers to help them do so.

##### **9.2.4.1 Support networks and interpersonal life stressors**

The systematic review stressed the need for treatment practitioners to pay attention to the quality and safety of women’s support networks in supporting or detracting from both substance use and PTSD recovery. Participants in this study also corroborated this as they described how some close relationships were the source of stress or repeated IPA, particularly emotional abuse. Women abused in childhood may not feel that families can provide the appropriate social support to help them cope with their current stressors (Harris et al., 2005; Stroud, 1999). In the context of experiencing ongoing IPA, women may withdraw from familial and friend support as a coping

strategy or may feel they have already exhausted support due to their drug use and feel unable to seek additional support (Panchanadeswaran, El-Bassel, Gilbert, Wu, & Chang, 2008). This reiterates the importance of wider sources of social support, beyond that of family and friends.

Researchers have argued that substance specific social support, such as participation in 12-step self-help groups, promote self-efficacy, self-esteem, and provide the opportunity to practice proactive abstinence-based coping skills learned in interventions such as Seeking Safety (Moos, 2007, Morgan-Lopez et al., 2013). Participants in this study used peer support in varying degrees; the number of peer support sessions ranged from 0-84 with two participants accounting for the attendance at the majority of these. One woman in early recovery described attending a meeting nearly every day since the intervention had ended, in attempts to 'keep busy' and surround herself in a different social circle. She sustained her abstinence throughout the study, despite the loss of support from the study treatment service. Findings from the Women and Trauma study (discussed in Chapter 3) echo the importance of abstinence-based peer support. The trial illustrated that peer support activities moderated the effect of the Seeking Safety intervention; women who engaged in additional 12-step affiliated peer support after the end of the Seeking Safety intervention, showed significantly reduced alcohol use at follow-up compared to women in the control group (Morgan-Lopez et al., 2013). Whilst attendance at 12-step programmes was not randomised, limiting casual inference, other studies of integrated trauma-specific interventions have identified a similar theme. In the Women and Co-occurring Disorders and Violence Study (WCDV) involving TREM, qualitative data illustrated that women in the intervention sites who practiced their recovery alone often relapsed in both drug and alcohol use (Harris et al., 2005).

The Stress-Buffering model proposes that social support helps buffer against the impact of stressful events (Cohen & Willis, 1985; Cutrona & Russell, 1987). The supportive actions of others are thought to enhance an individual's coping performance and positive perceptions of available support lead to stressful situations being interpreted less negatively (Lakey & Cohen, 2000). To this end, interventions to enhance the quantity and quality of general social support for those in substance use treatment are recognized as important interventions in their own right, particularly in the treatment of alcohol problems (Day et al., 2018; Litt et al., 2009; Miller & Wilbourne, 2002;



However, for women in this study, reflective of women in substance use treatment, IPA and childhood victimisation were so prevalent in their lives it posed challenges to improving current social support networks, especially in a short-term intervention. Attention must be paid to how individuals in women's social networks are identified, ensuring they are conducive to safe and positive social support (Galvani, 2007). Although the Seeking Safety intervention was not designed primarily to target social networks intensively, the interpersonal topics form a third of the possible 25 sessions and are "*designed to help patients maximise the presence of supportive people and let go of destructive people.*" (Najavits, 2002, p.5). As outlined in Chapter 5, three interpersonal topics were selected for the version of Seeking Safety used in this study: '*Setting Boundaries in Relationships*', '*Healing from Anger*,' and '*Honesty*.' The empowerment and assertiveness study participants gained from these sessions will help their self-efficacy and autonomy in ways that may enable them to disentangle themselves from unhealthy relationships, and avoid them in the future (Brown, Melchior, Waite-O'Brien, & Huba, 2002). However, a certain amount of realism is also required in assuming how short-term interventions can really affect substantial changes in the presence of, or distancing from, supportive or destructive people, especially when some of these people are family members or ex-partners involved in co-parenting. Care must be taken in advising women with controlling partners, given the evidence that leaving such relationships is a risk factor for homicide (Metropolitan Police Service, 2003) and women cannot necessarily distance themselves from children who are acting abusively towards them (Home Office, 2016; Wilcox, 2012). Within the Seeking Safety intervention, women are asked to consider if there are any community resources they can draw upon that week, as part of the check-out process. In this study, the discussions tended to focus on other services, but facilitators could use this component as an opportunity for targeted discussion about safe and supportive friends or family.

#### **9.2.4.2 Responding to ongoing IPA experienced by women in treatment**

The systematic review revealed the lack of studies recording IPA experienced by study participants during the study period. Given that IPA has the potential to exacerbate PTSD symptoms and promote further substance use (Bailey, 2017; El-Bassel et al., 2005; Sullivan et al., 2016), the review concluded with a key recommendation that future studies should measure

repeated victimisation beyond baseline. The lack of monitoring of new IPA experienced post-baseline in most of the studies in the review precluded any further conclusions about the correlation with treatment outcomes. One of the US stakeholders interviewed, a leading researcher in trials of integrated trauma-specific interventions, also highlighted the neglect of researchers to measure ongoing victimisation and incorporate into the main analysis. Only one of the studies included in the systematic review explored the correlation with experiences of new victimization whilst participating in the intervention and participant outcomes (Mills et al., 2016). After controlling for baseline PTSD severity, exposure to new trauma (n=33, numbers of women unknown) was not significantly associated with change in PTSD symptom severity at follow-up (substance use was not explored). However, the trial did not include wider forms of IPA such as emotional abuse which may have either confounded or diluted the association. This is important because psychological abuse is a stronger predictor of PTSD than physical violence (Arias & Pape, 1999; Dutton et al., 2006). That is because living with psychological abuse creates a constant atmosphere of pervading threat and fear, which are insidiously damaging and contribute to maintaining PTSD symptoms such as hyper-alertness (Herman, 2001; Sackett & Saunders, 1999; Warshaw et al., 2013).

Therefore, this study was the first to measure IPA comprehensively, including emotional abuse, experienced by women during the intervention and follow-up. Nearly half of women reported experiencing at least one form of IPA, whilst participating in the Seeking Safety intervention, and nearly a third during the 3-month post-intervention period. This supports the use of a present-focused intervention, such as Seeking Safety, as past-focused interventions are deemed unsuitable for those experiencing ongoing abuse (Killeen et al., 2015; Mills, Back et al., 2012). Perhaps of most significance when considering contextual factors which impact on the Seeking Safety intervention, women who reported no new abuse during the study experienced greater decreases in PTSD scores over time, compared to those who experienced abuse. Moreover, the women who were not re-victimised experienced PTSD improvements that brought their average scores below the threshold for PTSD (<33 on PCL-5), something not experienced by the group as a whole. Although the statistical analysis did not find sufficient evidence to support this difference, this may well be due to the sample being underpowered to detect. However, the study

finding lends some weight to other research; secondary data analysis of a trial of psychological interventions for domestic violence survivors found that clinically significant change in depression (PTSD was not explored) was negatively correlated with ongoing victimization at the 12-month follow-up (Bailey, 2017). These associations with IPA and poor treatment outcomes have implications for substance use treatment services. It reiterates the importance of fully embracing new UK substance use treatment guidelines which state that, “*all drug services need competence in identifying and addressing the effects of trauma on services users and the effects of intimate partner violence or other domestic violence.*” (DoH, 2017, p.15). The employment of a specialist IDVA within the study treatment service is particularly rare within substance use treatment services and should be acknowledged as a model of good practice (Itzin et al., 2010). With the increasing funding cuts to services, such a specialist role will remain rare. However, services can still form strong partnership with IDVAs based in other local services, as highlighted by the practice of English stakeholders interviewed (Chapter 4), and recommended in commissioning guidance for services for victims of IPA and NICE clinical guidelines for responding to domestic violence, including intimate partner violence (Home Office, 2016a; 2016b, NICE, 2014). Strong service leadership which ensures intimate partner violence features on the agenda of daily case management meetings is also an example of good practice. This practice can and should be championed by management in all substance use treatment services, seeking advice from specialist women’s services when needed. The service manager involved in this study gave illustrations of the consequences to women’s safety when treatment services do not have sufficient understanding of intimate partner violence. For example, one woman was severely beaten by her partner and hospitalised whilst *she* was attending a mixed-gender programme for perpetration of violence within another substance use treatment service in the borough. A better understanding of the complexity of intimate partner abuse by the staff, including the links to women’s perpetration of violence, and ongoing monitoring of risk may have avoided this outcome.

Despite the ‘safety-first’ approach of the study treatment service and attempts to ensure ‘zero-tolerance’ on sexist or derogatory behaviour by male service users, participants in this intervention study still reported harassment on-site and externally, for example, at their places of work. However, there was also evidence that the treatment service responded appropriately e.g.,

banned male service users from attending. This reiterates how all substance use treatment services should pay attention to how their policies and procedures maintain a safe environment for women, in order to support retention, and to ensure women's trauma symptoms are not re-triggered by the behaviour of male clients e.g. shouting and aggressiveness. This is a key foundation of TIP.

The qualitative data also identified areas for improvement for the study treatment service in terms of fully embracing TIP. One facilitator expressed concerns about the level of training provided to all service staff at the study treatment service in order to deal with the complicated presentations of service users due to IPA. As part of the study, a one-day training on TIP was provided to all staff, with an initial plan to provide a second follow up training during the course of the study. However, this, along with more sustained focus on developing a wider organisational approach to TIP, was not forthcoming during the course of the study, which may be in part due to the impending service closure. Echoing the findings from other UK stakeholders, a mere training session is not sufficient for developing organisational practice and is only the start of the journey. There is now a strong body of international TIP practice guidance and fidelity checklists tailored to substance treatment services (e.g. Falloot & Harris, 2014; SAHMSA, 2011) which could be used to monitor the development of, and adherence to TIP within substance use treatment systems.

#### **9.2.4.3 After-care and ongoing service provision**

The study treatment service closed shortly after the end of the second Seeking Safety group after losing its contract as part of a re-tendering of all substance use services in the borough. This is not unusual in the current commissioning climate in England whereby constant re-tendering processes result in substance use treatment services changing every three years, which have been described as costly, disruptive and complex, with negative effects on service users (ACMD, 2017; Day et al., 2018; Drummond et al., 2017; MacMillan, 2010). For some women in the study, the impact of the study treatment service closure shortly after the end of the second group, interfered with their recovery and directly contributed towards relapse at the final follow-up point. Advocates of treating substance use in a similar way to chronic disease management, stress the importance of long-term provision of care and monitoring beyond the initial therapeutic

interventions (McLellan et al., 2013). Regardless of one's philosophical understanding of addiction, the continuity of care is not a new revelation (Covington, 2000; McKay, 2005; 2009; Orford, 2008). In a prison based study involving Seeking Safety, attendance at 'after-care' sessions post-release was associated with better drug use reduction (Zlotnick et al., 2009). After-care was the bedrock of the service philosophy of the study treatment service before it closed, with the service manager describing the provision of 'un-official' after-care long after it was funded. The interviews with stakeholders from England (Chapter 4) also highlighted the importance of activities to promote women's transition from a world schema based on their sense of self as 'mad or bad,' to one of positive self-identity rooted in a healthy social community. Several substance use practitioners interviewed discussed the importance of providing social activities, access to volunteering, and employment skills training as part of later stages of their general treatment model, also supported in clinical guidelines for treatment of drug use (DoH, 2017). This work needed to continue long after the substance specific interventions had concluded. Other qualitative research has also identified the importance non-drug-related activities and relationships to supported new self-identities, as important for sustaining recovery from substance use after leaving treatment (McIntosh & McKeganey, 2000; Mockus et al., 2005).

The closure of the service thus closed-off opportunities for women to move onto these phases of recovery support, which were also offered as part of the after-care service. The participants who relapsed were also the same women who described the study treatment services as 'not just bricks and mortar' and 'like a family.' This loss of this extended 'treatment as usual' alongside the Seeking Safety intervention was clearly a barrier to sustaining recovery and/or help-seeking for them. Other qualitative research with women, 12-18 months after participating in an integrated trauma-specific groupwork, highlighted the fragile nature of recovery, reiterating the importance of ongoing support: those who were unable to maintain the improvements in mental health and substance use experienced following the end of the intervention, spoke about their battles with depression and loneliness, ongoing feelings of powerlessness due to histories of abusive relationships, and individual life crises such as the arrest of a son or death of a family member, as sufficient to invoke their spiral back to substance use (Harris et al., 2005). In this feasibility

study, nearly 70% of participants still met the clinical cut-off point for PTSD diagnosis suggestive of their need for ongoing treatment to address their PTSD symptoms.

#### **9.2.4.4 Making the case for commissioning integrated trauma-specific interventions**

The recommissioning of the study treatment service during this study reflects the wider challenges of substance use treatment services who are being asked to deliver services with substantially reduced budgets, facing on average 30-50% cuts (Buck, 2016; Drummond et al., 2017). However, in England, ongoing cuts to addictions services over the past decade due to the devolvement of public health spending to local government, and removal of ring-fenced budgets has resulted in a scarcity of psychologists working in substance use treatment (ACMD, 2017; Buck, 2016; Drummond et al., 2017). This means less investment in staff and reduced funding of all the holistic components which support the psycho-social interventions themselves; for example, the provision of a hot meal which was an important aspect of the wider service environment in the study treatment service. In a review of financial resourcing of substance use treatment in the UK between 2001-2015, the Advisory Council on the Misuse of Drugs (ACMD) concluded that the under-resourcing of services has compromised the quality and effectiveness of treatment and promoted a greater disconnect between substance treatment and other health structures (ACMD, 2017). The implications for the workforce are that services try to compete for commissioning contracts through the use of non-professional staff, volunteer workers and recovery champions (Recovery Partnership and Adfam, 2017) in attempts to cut costs (Dickinson et al., 2017). In response to this, the ACMD has urged the government to conduct a review of the national substance misuse workforce and set an optimal target for the balance of clinically trained psychologists, psychiatrists and less qualified staff and unpaid volunteers (ACMD, 2017). Whilst the US stakeholders maintained that present-focused interventions, such as Seeking Safety, did not require clinical psychology or psychiatry training, this study did identify that the group facilitators required substantial expertise in working with traumatised women and substance use, particularly in group-work, and the specialist expertise in PTSD brought by the external facilitator was important. This necessitates the employment of skilled staff, which, along with the earlier recommendation for investment in training in supervision, is an important consideration for services wishing to adopt trauma-specific interventions such as Seeking Safety. Warnings should

be heeded from the experience of developing TIP within the criminal justice system in England (Ministry of Justice, 2018). Despite this welcome focus on TIP, practitioners have expressed concern about the lack of appropriately qualified professionals delivering the trauma-specific group-work interventions in prison. Prison residents are trained to deliver the programme to other residents, and although they are supported in doing so by trained prison officers, there are limited mechanisms to guide the facilitators to deliver the material in adherence to the manual and a lack of formal supervision and support for them (J. Kelman, Lead Psychologist, Women's Prison Estate, 11 November 2018).

It is within this wider context that attempts to roll-out specialised trauma-specific treatments, such as Seeking Safety, takes place. However, this sits within an environment of competing service demands requiring the attention of commissioners. For the study treatment service manager, the retention of women seen in both cycles of the group was higher than previously obtained in their other women's groups, and this justified the potential additional investments. The cost associated with supervision and training may also be worthwhile if they can be shown to decrease staff turnover, re-admission rates and improved service user outcomes (Killeen et al., 2015). However, there are also several key policy drivers which may bolster efforts of substance treatment services wishing to justify inclusion of a trauma-specific interventions, and TIP, to commissioners. Firstly, the renewed government focus on the need to promote better mental health provision for women, supported by Public Health England and Health Education England, and overseen by a government Taskforce, should ensure the issue of TIP is on the agenda (Department of Health and Social Care and Agenda, 2018). This is supported by the re-issue of the substance use treatment clinical guidelines that have promoted TIP as core business (DoH, 2017). Furthermore, the recent revision of NICE PTSD clinical guidelines (Dec 2018) no longer support a sequential approach to the treatment of PTSD and substance use and recommend that those with substance use should not be excluded from evidenced-base PTSD treatments. The guidelines recommend that clinicians *"help the person manage any issues which might act as a barrier to engaging with trauma-focused therapies (past-focused interventions) such as substance misuse...."* (p. 21). Other recommendations include focusing on establishing *'the safety and stability of a person's personal circumstances'* (p.21). It may well be timely for substance treatment services to form

partnerships with specialist women's services in order to support NHS mental health services to respond to these changes, as part of a stepped-care model.

### **9.3 Considerations for future feasibility studies**

Section 9.2 has discussed key considerations for acceptability and feasibility of delivering an adapted version of Seeking Safety within a substance use treatment setting in England. This has highlighted the importance of certain adaptations to the Seeking Safety content that should be maintained, as well as process and format issues that require attention, particularly when coaching facilitators towards adequate adherence to the intervention. This section moves on to discussing the additional learning harnessed from the study, which could contribute towards a next stage feasibility study such as a pilot RCT (Eldridge et al., 2016) involving Seeking Safety; namely recruitment and eligibility criteria, enhancing study retention, acceptability of study measures, service user collaboration and implementing effective fidelity monitoring.

#### **9.3.1 Recruiting eligible participants**

Chapter 7 demonstrates the feasibility of the eligibility criteria with 30 out of the 38 women screened meeting eligibility criteria of sub-threshold PTSD and IPA experiences, and 21 women consenting to participate in the intervention. In fact, the majority of women recruited met criteria for probable PTSD diagnosis (n=18, 94.74%). Studies across multiple countries have demonstrated that IPA multiplicity is associated with PTSD prevalence (Dorrington, 2014; Natcen, 2013; Rees et al., 2014). The repeated exposure to IPA in childhood and adulthood reported by women in this study may explain the high PTSD prevalence. All women reported a history of intimate partner violence, again congruent with findings from a robust meta-analysis which demonstrated vastly increased odds (OR 7.34 95% CI 4.50–11.98) of experiencing intimate partner violence amongst those with a diagnosis of PTSD, as well as strong associations with anxiety and depression (Trevillion et al., 2012).

##### **9.3.1.1 Participant characteristics**

The participant backgrounds regarding substance use severity and co-occurring mental health problems, were reflective of the diversity of women found in other pragmatic trials, identified in



the systematic review. Most participants were poly-substances users (74%). The most frequently reported problematic substance used was cocaine or crack cocaine (63%), reflecting the recent rise in use of these drugs seen nationally among people entering treatment (Public Health England, 2018). However, the proportions reporting opiates (33%) and alcohol (21%) as the most problematic substance were lower than the general female treatment population in England (47% for opiates and 36% for alcohol) (Public Health England, 2018). One explanation for the low proportion of women in treatment for alcohol use was that there was a specialist alcohol treatment service operating in the borough that did not refer women to the study, despite efforts to include them. Given the focus on recovery at the service where the intervention was delivered, 58% of participants were abstinent from any substances and others were in varying stages of recovery. The mean ASI alcohol [0.1, (SD 0.23)] and drug scores [0.11 (SD0.15)]<sup>45</sup> were lower than other studies of trauma-specific interventions delivered to women (McHugo al., 2005; Zlotnick et al. 2009). Future studies involving other substance use treatment services may result in a participant demographic with more severe active substance use, re-iterating the importance of the content and format adaptations previously discussed.

The Women and Trauma study involved the largest trial of Seeking Safety and also included women in various stages of substance use recovery, with nearly half reporting recent seven-day abstinence when entering the study (Hien et al., 2009). This factor may have contributed to the lack of average group treatment effect seen in substance use and PTSD in the trial (Hien et al., 2009) because secondary data analysis revealed two sub-groups of Seeking Safety participants who did improve, in comparison to the control: women with baseline alcohol use experienced improved PTSD at follow-up (Hien, Campbell, et al., 2010); and women with more severe substance use who had sustained improvements in PTSD during the study, experienced reduced substance use at follow-up (Hien, Jiang, et al., 2010; Ruglass, et al., 2014). In the PhD feasibility study, it was not possible to undertake such subgroup analysis. However, this wider literature

supports the targeting of Seeking Safety at women with more severe substance use in future studies.

The socio-demographic and other participant characteristics in the study were reflective of those found in many of the other study samples identified in the systematic review which comprised all female samples (Chapter 2): >35 years, with basic education level (GCSEs), around half identifying as Black or Minority Ethnic (BME) and a third living with children under the age of 18 years. One of the US stakeholders interviewed stressed the importance of having treatment staff that reflect the diversity of the service users. This study was able to observe this good practice with one facilitator identifying as BME and another whose first language was not English.

The original target of 24 women was reduced to 22 after the first group cycle, upon request of the facilitators who stated that smaller group sizes were needed in order to manage the group dynamic. Participants supported this decision when interviewed at follow-up, suggesting group-sizes are an important aspect of intervention acceptability. The service confirmed that during the period of the study approximately 40 women were enrolled at the study treatment service which highlights how recruitment of eligible women for two control groups in that short period of time would have been unfeasible. Whitehead and colleagues (2016) have offered suggestions for pilot sample sizes that would minimise the overall trial sample size, particularly when the standardised effect size is estimated. According to these recommendations, a 90% powered main trial based on an estimated small standardised difference (0.1 - 0.3) would require 25 participants per treatment arm. This, taken together with the requirement for smaller group sizes, has implications for future research that will necessitate larger sample sizes; engaging several treatment services and/or delivering multiple cycles of the group over an extended period of time.

#### **9.3.1.2 Selecting study partners**

There were very few referrals from partner services. This may be due to several reasons; one of these may be due to the re-commissioning of services, as discussed previously. However, other research has shown that not all substance use treatment staff believe it appropriate to address trauma within the context of substance use treatment (Blakey & Bowers 2016; Hien, Cohen et al.,

2009). Some of these reasons are due to the beliefs of the individual staff, for example belief that substance use must be addressed first for fear of increased substance use by women as they discuss issues related to trauma; others are more systematic and related to lack of funding and lack of workforce preparedness (Blakey & Bowers, 2016). In the feasibility study, staff involvement in the identification of eligible women from their treatment service was important for successful recruitment; the interest of staff was underpinned by their acknowledgement of trauma backgrounds experienced by the majority of their female service users and the belief that a new group-work intervention was needed to meet their multiple complex needs. Attempting to recruit within a service where staff do not embrace these beliefs may impede recruitment. In addition, trials recruiting wider drug using populations are often hampered by challenges of clinic staff that have sufficient interest, time or capacity to recruit suitable participants (Ashery & McAuliffe 1992; Patel, Doku & Tennakoon, 2003; Thomson et al., 2008). Therefore, attention must be paid to the selection of study treatment services in future studies. The qualitative interviews with stakeholders provided the opportunity to assess the suitability of potential study sites in terms of interest and viability, and a similar auditing process may be useful in future research (Elliot & Mihalic, 2004; Patel et al., 2003).

### **9.3.2 Aides to recruitment**

The engagement of a female service user representative from the study treatment service was helpful for suggesting the 'informational sessions' and for promoting the study amongst her peers. Other studies recruiting women facing stigma have also had positive experiences of using peer or community recruiters in attempts to reach women (Alvarez et al., 2006; Walker et al., 2017) and it would thus appear an important aid to successful recruitment. Understanding women's motivations for participating in research can help influence the recruitment material and study advertisements. In the qualitative interviews, participants described a desire to better understand themselves and their trauma, as a strong motivator for taking part. As some women were attracted to learning more about PTSD, such terminology in recruitment materials should be included. As part of co-development of the study design, women with lived experience recommended that to enhance recruitment, women should be advised that participating in the intervention and the study did not require talking in detail about IPA.

### 9.3.3 Aides to study and group retention

In terms of study retention, based on studies with similar treatment populations (Fowler & Faulkner, 2011), the study protocol estimated a 30% study attrition rate. At the final follow-up time-point (3-months post-intervention), attrition was 16%. This is superior to other studies of majority female samples treated in community settings followed up at three months (Hien et al., 2009; McGovern et al., 2009; Najavits et al., 1998). Women demonstrated good participation in the intervention with nearly 70% attending the stipulated minimal dose exposure of 50% of sessions, outlined in the study protocol (Chapter 6). A similar group retention rate was found in the largest trial of Seeking Safety (Hien et al., 2009). Several reasons may explain the good group retention rate. First, the substantial number of women reporting abstinence in this study, similar to those in the study by Hien et al., (2009), may have contributed to the high attendance at the sessions. The large Seeking Safety trial found that baseline PTSD severity or substance use were not related to attendance (Ruglass et al., 2012). However, in the feasibility study women with more active substance use struggled with participation. For example, half of the women attending less than six sessions were using illicit substances heavily at baseline. Two women who dropped out of Group 1 were in active heavy substance use. Both chose to re-join the study and start Group 2; one woman had stopped her heroin and crack use when re-entering the group and she was adamant this contributed to her high attendance in the group. Other practitioners working in a trauma-focused residential service have highlighted this issue, believing it was easier to develop therapeutic relationships with women who were, *'fully detoxed, used to attending treatment groups, determined to stop using substances, and curious about exploring their trauma experiences alongside their addiction.'* (Tompkins & Neale, 2016, p.5).

Secondly, the gendered, relational and safety-first approach driving the service delivery model appeared to provide a treatment environment conducive to the needs of women, as illustrated by the higher than national average female service user base (40% vs 30%; Public Health England, 2018). This may have contributed towards good retention. Thirdly, women in this study found the texts/phone calls from me, reminding them about the sessions and interviews, acceptable and helpful. Whilst there has been little evaluation of the effectiveness of using text message

reminders in substance use treatment, the evidence for its use in general healthcare is positive for enhancing engagement (Milward, Lynskey & Strang 2014). I believe that this ongoing contact and rapport between the participants and me may have helped increase retention in the intervention and follow-up interviews.

While this study did not provide financial or other incentives for group attendance; lunch and refreshments were provided at each group session and reimbursement for time was given in the form of gift vouchers for each research interview attended. Of all trials identified in the systematic review, only one study provided attendance incentives; a \$25 gift voucher for each session attended (Gilbert et al., 2006). This resulted in over half of women attending all 12-sessions and the remaining half attending between 9-11-sessions, and a study attrition rate of 9% at the three-month follow-up (Gilbert et al., 2006), much higher than the other trials included in the systematic review. Contingency management has shown promise for increasing retention in other trials (Milward, Lynskey & Strang 2014, European Monitoring Centre for Drugs and Drug Addiction, 2016), and therefore could be considered in future research of Seeking Safety, especially if targeting those with more severe substance use, which may create challenges for retention. Other studies have highlighted that trial participants may be more inclined to take part in trials if the study treatment centre is close to their home and/or travel reimbursement is provided (Neale et al., 2018). None of the participants in this study cited transport costs as a barrier to attendance however one participant cited childcare as the reason for two missed sessions during half-term holidays.

Finally, retention may be due to the shortness of the intervention (Hien et al., 2009). Therefore, whilst participants and staff recommended extending treatment in order to enhance participant outcomes and acceptability, the length must also be feasible within the constraints of clinical research trials, particularly as retention is an important part of internal validity (Hien, Cohen et al., 2009; Killeen et al., 2015). A next stage pilot feasibility study could consider assessing the feasibility of running the Seeking Safety intervention over 12 weeks [which is compatible with government targets for treatment retention (NHS, 2005)] maintaining the twice weekly sessions

and the same number of topics, split over sessions and combined with additional mind-body activities.

### **9.3.4 Improvements to study measures**

The systematic review of Chapter 3 recommended that future research of integrated interventions should comprise both qualitative and quantitative measurement of potential intermediary outcomes including differing coping skills, physical and emotional safety measures, negative cognitions, positive self-identity and emotional dysregulation. The feasibility study adopted this in the choice of measures and the results highlighted that, for the most part, all the measures were acceptable with a few exceptions, discussed further below. Participants were offered the option of self-completing the questionnaires or having them administered. All participants opted for the latter option, which resulted in limited missing data.

#### **9.3.4.1 Measures of IPA**

The Composite Abuse Score–Short Form (CAS-SF) (Ford-Gilboe et al., 2017) measured intimate partner violence and was originally chosen for its brevity and desire to reduce participant burden, whilst maintaining a comprehensive focus on all facets of intimate partner violence. I was not aware, however, that the new measure had not been used in other intervention studies to date, and the scores are not compatible with the original full version (Hegarty, Bush & Sheehan, 2005), making the interpretation of composite score problematic. The CAS-SF was not selected for use as an outcome measure in this study and the adaptations made to the questionnaire, for use at both follow-up periods, reflect that (see Appendix 21). Instead the measure was used to identify women experiencing any new abuse since the last assessment, as a contextual factor impacting on other outcomes, as recommended by findings from the systematic review. Further work is required to explore how the CAS-SF can be used to measure change over time and alternative ways of scoring; work that is currently underway (Dr Ford-Gilboe, personal communication, 7 August 2017).

Furthermore, women in the feasibility study struggled to identify with the term ‘intimate partner’ as someone with whom they were ‘in a relationship’ with. Whilst some women stated they were

not currently in a relationship, they then went on to give positive answers to a number of abuse items, instigated by men (and in one case a woman) who were described as 'friends' or 'acquaintances.' Women using drugs have a complex web of intimate relationships, including 'drug relationships' and men with whom they exchange sex for drugs or other goods (Gilchrist et al., 2015; Hammersley et al., 2016; Mayock, Cronly & Clatts, 2015). Women may or may not identify these people as 'intimate partners' but the nature of their abuse operates as if they were. This has implications for how this questionnaire is introduced when being used with this study population.

The importance of measuring wide-ranging IPA has been previously discussed. However, the shortened version of the IPA checklist that I devised for the study follow-up timepoints did not capture the frequency or severity of incidents. This may be an important contribution to outcome, as suggested in other studies that found increasing incidents of IPA contributed to increased prevalence of PTSD and substance use (Natcen, 2013; Rees et al., 2015). This is something that should be considered in future studies.

#### **9.3.4.2 Measures of drug and alcohol use**

Chapter 7, section 7.1.6.4, identified some difficulties with the subjective nature of questions in the Addiction Severity Index-Lite (ASI). Similar concerns have been identified by other researchers, and the validity of the scoring methods questioned (Olav-Melberg, 2004). For example, to get a high score for the drug and alcohol score, one author points out that that you need to use "all kinds of drugs every day in addition to getting drunk (every day)" which makes the upper empirical limit for these scores much lower than the theoretical limit of 1 (Olav-Melberg, 2004). Therefore, although the ASI is widely used in studies, including many identified in the systematic review, and was originally chosen for its brevity, it is worth considering other measures of substance use outcomes in future studies. For example, The Time Line Follow-Back (TLFB) asks for more detailed information about the amount of drugs and alcohol consumed and the duration over a specified period, using a blank calendar (Sobell & Sobell, 1995). The measure is well validated (Fals-Stewart, O'Farrell, Freitas, McFarlin, & Rutigliano, 2000; Sobell & Sobell, 2000; Savage, Ritchey, & Fulmer, 2002) but training is recommended for administration, and is

longer in duration than the ASI-Lite, which may increase participant burden in the interview. However, given the problems with the ASI, it is worthy of further consideration.

Given the number of women reporting abstinence at baseline and the role of self-efficacy at baseline in predicting outcomes (Cummings et al., 2010; Trucco et al., 2007), future studies should also consider measuring other aspects of substance use such as self-efficacy. For example, the Drug Taking Confidence Questionnaire (Annis & Martin, 1985) uses eight subscales of high-risk situations for relapse to assess self-efficacy for resisting alcohol and/or drug use, has good psychometric properties, and has been used in other studies of women-only substance use group-work (Cummings et al., 2010; Skylar, Annis & Turner, 1997).

The eligibility criteria did not involve a screen for substance use severity. This was acceptable in the current study because it relied largely on recruiting from substance use treatment services. However, future research may wish to recruit beyond substance use treatment services, for example, women's refuges or other community-based services, and therefore a screen for substance use would be advisable. Both the Alcohol Use Disorders Identification Test (AUDIT) (Saunders, Aasland, Babor, Fuente, & Grant, 1993) and the Drug Use Disorders Identification test (DUDIT) (Berman, Bergman, Palmstierna, & Schlyter, 2005) are available in the public domain, do not require training, and are quick and easy to administer (Deady, 2009), and demonstrate good psychometric properties (Allen, Litten, Fertig, & Babor, 1997; Bohn, Babor, & Kranzler, 1995; Daeppen, Yersin, Landry, Pecoud, & Decrey, 2000; Shields & Caruso, 2003, Berman, Bergman, Palmstierna, & Schlyter, 2005).

### **9.3.5 Service user involvement in research**

The collaborative involvement of women with personal experience of IPA and substance use ('experts-by-experience') was promoted in this study for both philosophical and pragmatic reasons. As outlined elsewhere (Chapter 5-6), the small group of women were involved in recruitment material design, questionnaire testing, choosing the content and topics to be used in this in Seeking Safety, reviewing the intervention hand-outs, and participating on the Steering



group. As discussed earlier the service user representative from the study treatment service also played an important role in aiding recruitment to the study.

Philosophically, collaborative approaches to research are important in order to attempt to dissolve the hierarchy between researcher and those being researched (Oakley, 1980, 1981). In the context of women who are often marginalised, such collaboration allows a space for their voices to be heard and recognised on a more equal playing field (Maguire et al., 2004; Reid, Tom & Frisby, 2006). However, I also recognise that this power imbalance still existed between me as 'the researcher' and the participants as 'the service user representatives', given the dissimilar positions we occupied particularly in terms of socio-economic class, education and health status (Phoenix, 1994; Tang, 2002). Moreover, this research study was researcher led; service user participation remained at the more consultative end as opposed to approaches that involve service users in conducting and leading the research (Higginbottom & Liamputtong, 2015, NIHR & INVOLVE, 2018).

Our collaboration, nonetheless, formed a highly iterative process whereby 'negotiated construction of meanings' were played out (Pillow, 2003, p.187) in order to agree the final content and adaptations. I personally found the experience crucial for ensuring the recruitment material was accessible and for identifying logical and practical issues regarding recruitment. The experts by experience both confirmed and disagreed with material adaptations that I had previously identified, leading to productive conversations. For example, they were keen that the format of the page layout was made more interesting with less text, using images where possible. They picked up on different language and terminology issues to the ones that I had identified and were focused on making the case study examples more applicable to the client base e.g., UK cultural references. It was through the input of the experts by experience that we also decided to take a more collaborative approach to the study participants' 'treatment agreement' (Najavits, 2002, p.73). The Seeking Safety manual provided a template and suggests copies are given to women in the first session. Instead, we asked women to review and suggest any suitable amendments, with the revised copy provided to participants at the following session. Such an approach fits well with TIP, which espouses the collaboration between practitioners and service users in treatment

decisions (Elliott et al., 2005; Harris & Fallot, 2002;). Two women provided the following feedback about their involvement as experts, indicating that they benefitted positively from taking part:

“The research was well thought out organised with much attention to detail. I felt a valued member of the team, myself and others were encouraged to participate, and I felt our voices were genuinely heard. I felt that service users were always a priority. Overall, I feel Karen led the research with great care, sincerity, compassion and understanding for all involved. On a personal level I reflected on my own life and where I may be able to get a bit more support from. I’m really glad I have been a part of something that is important and very useful and healing for the women at [study treatment service].” (Expert 1)

“I have really enjoyed the experience of working with Karen on this research, I have learnt a lot and it has felt good that my past experiences of domestic abuse have been of value in informing the project and helping to shape ‘Seeking Safety’ programme for women. In the future I would love to facilitate a Seeking Safety group or individual group sessions.” (Expert 2)

The collaboration highlighted how the process of service user involvement requires a longer time period than anticipated and necessitates being flexible and creative about where and when to meet in order to facilitate ongoing involvement. A decision was made early on to allocate sufficient budget to be able to give financial compensation to the experts by experience, as recommended by NIHR (NIHR & INVOLVE 2018). The service user representative from the study treatment service who advised on the Steering Group was provided with cash, upon recommendation from the service manager. The other women were provided with shopping vouchers. All were appreciative of this recognition of their time.

### **9.3.7 Fidelity monitoring in future research**

The resource constraints of substance use treatment mean the focus on adherence to manuals and provision of adequate supervision is of less consistent quality than in research studies (Whittingdon & Grey, 2013). In this study, the administration of the fidelity monitoring tool and its use to ‘coach’ the facilitators were also constrained by financial and practical considerations. These included the limited availability of skilled fidelity assessors in the UK, insufficient training completed by myself for the Seeking Safety Fidelity Rater certification, and no provision for early cross-checking of fidelity score sheets with an expert in order to assess accuracy. Najavits (2004) advises that as part of a research study, all prospective facilitators complete a practice run of all

the topics they plan to deliver with a non-study group before the fidelity monitoring begins. This informed the decision in this study to only administer fidelity scores for the second group cycle. In future studies the budget should allow for consultancy support from a certified Seeking Safety fidelity rater, and sufficient time planned for training and preparation time of facilitators in the lead up to delivery.

This next section provides key recommendations for practice, policy and future research and is followed by an overview of the strengths and limitation of the study, before providing a summary and final conclusions.

## **9.4 Recommendations for practice, policy, and research**

### **9.4.1 Practice – developing TIP and trauma-specific interventions**

- Services wishing to deliver integrated trauma-specific interventions such as Seeking Safety should first pay attention to developing organisation wide TIP. Checklists and guidance are now widely available to do this (see Fallot & Harris, 2014; SAHMSA, 2014). A number of UK services also now offer organisational training however, this should be seen as the first step in instigating wider-organisational change, which should be supported by a strategic programme of change (see Against Violence and Abuse and Solace Women's Aid, 2017);
- Whilst the group-format comprising women with shared experiences of IPA provided therapeutic benefits in itself, attention must be given to ensuring group cohesion and therapeutic alliance is maintained and the topic content is delivered at the appropriate pace;
- Women valued the provision of coping strategies for emotional regulation which centred on the mind-body connection and using compassion to address negative cognitions; strategies which could be incorporated into standard group-work programmes. As well as the grounding techniques in Seeking Safety, practitioners can draw ideas from: Covington, 2016; Lee, 2012; and training on emotional regulation available from the National Center for PTSD online <https://webstair.org>

- To deliver integrated trauma-specific group-work interventions, substance use treatment services should consider bringing in external expertise in IPA and PTSD to develop their practice, and for co-facilitation of trauma-specific groups, particularly in the early phases of adoption;
- Mixed-gender services need to pay particular attention to the safety of the service environment for women, particularly in regard to safety from (ex)-partners and predatory male service users, by ensuring suitable policies and procedures are in place;
- Services should adopt strong multi-agency working with local domestic violence services and seek advice from local IDVAs where needed (see NICE, 2104);
- Regular supervision delivered by senior clinicians with experience of delivering trauma-specific interventions, along with managerial support for self-care, should be a core part of the workforce management policy.

#### **9.4.2 Practice – Seeking Safety specific**

- The Seeking Safety coping skills described as helpful by women suggested the importance of activities that focus on the regulation of emotions, re-framing of negative cognitions using a compassionate approach, and building of self-esteem and self-identity;
- Topics should be spread over several sessions and groups should be kept to a closed enrolment format to ensure group cohesion;
- The inclusion of sensory-based objects and more grounding strategies should be incorporated into every session;
- Flexibility should be provided for adherence to the intervention, which prioritises therapeutic alliance and group cohesion and sufficient budgets allocated for training and supervising new facilitators. These aspects appeared to strongly influence the acceptability of the intervention by treatment staff and participants. Advice can be sought from the intervention author, Lisa Najavits via [www.treatment-innovations.org](http://www.treatment-innovations.org)

### **9.4.3 Policy**

- Policy makers, commissioners and funders must ensure that vital women-only services for women facing co-occurring issues are maintained in the face of brutal funding cuts. As recommended by a recent government mental health taskforce (Dept. Health and Social Care & Agenda, 2018), service guidelines and service specifications used in tendering processes should specify how they will assess for meaningful TIP in service delivery;
- In the USA, government funded training initiatives have supported the roll-out of TIP in substance use treatment (Capezza & Najavits 2012; SAMHSA, 2014), which would also be beneficial in the UK;
- Given the recent support by NICE for extending trauma-specific interventions to people with substance use, commissioners and funders should promote a stepped model of care; engaging joint working partnerships between substance use treatment services offering first stage safety and stabilisation interventions for trauma and PTSD, and mental health services offering second stage treatments, such as trauma-focused CBT and EMDR;
- Commissioners should also pay attention to the importance of continuity of care and the need for longer-term interventions for women with co-occurring issues; given the complexity of the challenges they face; in order to avoid the revolving door syndrome of service access.

### **9.4.4 Future research**

- A next stage pilot feasibility study (Eldridge et al., 2016) should assess the feasibility of: 1) a longer Seeking Safety group delivered for 12 weeks; maintaining the twice weekly sessions and the same number of topics, split over sessions and combined with additional mind-body activities; and 2) randomisation to a control group;
- Sample size calculations for future controlled trials should factor in the abstinence rates anticipated, when determining the power needed to detect substance use change. PTSD would appear the most suitable primary outcome;

- Consideration should be given to implementing two-stage research design. The first stage would involve action research (Hughes, 2008; Meyer, 200) to develop the capabilities of organisations to effectively deliver meaningful TIP, before moving on to the second stage evaluation of a trauma-specific intervention;
- Future intervention trials aimed at improving PTSD should ensure measurement beyond treatment effectiveness, to better identify which subgroups may benefit most, potential mechanisms of action and contextual factors impacting success (or failure);
- Future research with women facing co-occurring issues should employ comprehensive measures of IPA, assessed at all follow-up points and factored into the main analysis; measures should also be employed to identify the type of coping skills most beneficial for particular PTSD symptom clusters and substance use cravings.

## **9.5 Strengths and Limitations of the PhD study**

The UK is just at the beginning of the journey towards TIP and the implementation of integrated trauma-specific interventions aimed at PTSD and substance use. This study contributes the first important steps in that journey. The subject matter is significant, timely, and relevant to the substance use treatment and policy sector. Individual strengths and weaknesses of phases 1, 2 and 4 are discussed further below.

### **9.5.1 Phase 1 Systematic review: strengths**

The systematic review was the first to synthesise secondary data analysis and process evaluation for both psychological and mindfulness-based treatments (Bailey, Trevillion & Gilchrist, in press), with a focus on women who have PTSD symptoms and substance use. The review adds to our existing knowledge which had previously only focused on treatment effect; by providing analysis regarding subgroups who may benefit most, mechanisms of action and other contextual factors, e.g. ongoing victimisation, which impact on treatment success. A comprehensive two-stage systematic search strategy was utilised using several authors to cross-check eligible manuscripts and assess quality. Principles of thematic analysis, common in qualitative research, were used in

the narrative analysis. The description of this process provided a level of transparency and trustworthiness of the final results. Emphasis was placed on drawing out the key themes re-occurring across a number of studies, particularly where quantitative and qualitative data could be triangulated.

### **9.5.2 Phase 1 Systematic review: limitations**

The review contained limited discussion on past-focused interventions due to a lack of controlled trials in this category where women comprised the majority of participants. Substantial attention was given to the findings of supplementary information related to two trials, the Women and Trauma study and the WCDV study. The secondary data analyses in the Women and Trauma study were part of 19 analyses performed on a moderately sized trial, and due to this multiplicity and the lack of adjustments for the many comparisons, caution should be made when interpreting the results. In two outputs examining moderators, the participants were not randomized to the subgroups examined and the mediator analyses are exploratory in nature only. The review also drew heavily on the process evaluations attached to the WCDV multi-site study, a study which bears the inherent weaknesses of a non-randomised design and which showed significant heterogeneity across sites. Hence the study authors suggested caution in estimating the strength of the overall treatment effects (McHugo et al., 2005), which would extend to the associated secondary data analyses. Moreover, the three qualitative studies all suffered from different methodological constraints limiting their generalizability to the wider female population with co-occurring PTSD and substance use. In two studies it was unclear how many of the sample was experiencing current or sub-threshold PTSD and/or severity of substance use at baseline. Therefore, conclusions reached based on these samples may be better generalised to women who have experienced significant levels of traumatic events, rather than women with PTSD. Furthermore, the WCDV study involved an integrated trauma-specific treatment and wider integrated and trauma-informed services, and therefore much of the supplementary information does not exclusively focus on the trauma-informed treatment. However, care was taken to select information that pertains to, or has relevance to, the delivery of the integrated interventions. A further limitation is that one author (KB) undertook the development and assignment of codes, and the final development of themes, used in the thematic analysis. This meant that procedures

usually employed in qualitative analysis to ensure rigour, such as cross-checking of codes and themes, did not take place. Finally, the review included eight primary studies and their corresponding five supplementary studies that included samples of women and men. However, across all themes, data from these studies (which comprised 21% of all studies) are presented in triangulation with women only studies and taken together provide useful considerations for women's treatment going forward.

### **9.5.3 Phase 2 Stakeholder consultation: strengths**

Many of the criteria of good quality qualitative research were present in this study phase including significance of topic, rich rigor, sincerity, and credibility (Tracy, 2010). It is the first to shed light on how practitioners from a range of disciplines and services in England are attempting to address women's experiences of IPA, PTSD and substance use where precedence for both TIP and integrated interventions is limited. In terms of rigour, the data collection were made transparent to the reader, with copies of topic guides provided in the appendices. The data analysis process, in terms of how the raw data were transformed into the final themes, was explained in a step-by-step and transparent manner. Code checking was provided by a second researcher and high inter-rater reliability achieved, thereby guarding against individual researcher bias. Whilst the focus remained on certain models of integrated interventions, the eligibility criteria for England was also wide enough to include practitioners delivering their own interventions developed in house. Recruitment of the samples in both countries was guided by the over-arching objective to harness the expertise from practitioners, which would specifically inform the later phases of the study. Whilst this may have narrowed the focus of the sample selection, it was pragmatic with a view to the overall goals of the PhD study. Credibility comprises trustworthiness and plausibility; 'thick description,' allowing a variety of participant quotes and the context in which they were said, dominated the results. Attempts to highlight minority views were apparent. Combined with the learning from the systematic review, this consultation work provided a stronger case for decisions made in the selection and adaption of the Seeking Safety intervention (Phase 3) and feasibility study (Phase 4).



#### **9.5.4 Phase 2 Stakeholder consultation: limitations**

Limitations to this study phase related to the sampling. Firstly, the focus on England means the results may not be reflective of the practice in the other UK nations, particularly Scotland whose health services operate differently (Scottish Government, 2012). In England, attempts were made to select practitioners from multiple sectors who used a variety of pre-existing and/or newly developed programmes. At least two contact attempts were made to all those expressing interest, however some substance use treatment services were unavailable for interview. Nevertheless, whilst theme saturation was not the basis for the selection of the sample, after completing 14 interviews, limited new codes were generated and no new overarching themes established. Whilst the use of realist interviewing may result in overly directed questioning, the balance with traditional qualitative semi-structured interviewing elicited narratives beyond programme evaluation and allowed flexibility for participants to talk about topics they deemed important (Bryman et al., 2012). Many participants felt comfortable disagreeing with the theories proposed by the researcher, suggesting that the methodological approach was not inherently biased.

The US sample was purposively selected to include services and researchers involved in well-known present-focused interventions delivered in the group-work format. This was to ensure the most useful data for informing the next phases of the PhD study. The sample selection was regulated by constraints of time and resources and as a result focused on only a few states in the north east of the USA, where the majority of the previous trials had been conducted. As a result, the research does not purport to reflect the views of US stakeholders in general, or those delivering past-focused interventions.

#### **9.4.5 Phase 4 Feasibility study: strengths**

The final phase feasibility study, the first of its kind in the UK, was underpinned by a clear understanding of the purpose of this type of feasibility study (Eldridge et al., 2016) and was able to answer uncertainties relating to the study objectives: acceptability and suitability of Seeking Safety content; level of training and support for facilitators to deliver the intervention with adequate adherence to fidelity; recruitment and retention of eligible women; and wider contextual factors which impact these. The methodology followed good practice in the evaluation of complex

interventions (Craig et al., 2008; Moore et al., 2015). Whilst there were limitations in the study design, due to lack of a randomised control group, the richness of the study results, underpinned by a rigorous methodological approach have resulted in the production of valuable guidance for substance use treatment services looking to develop TIP and trauma-specific interventions, as well as highlighting learning for future a next stage feasibility study, such as a pilot RCT (Eldridge et al., 2016; Leon et al. 2011). It has highlighted potential pitfalls that are to be avoided (e.g. fidelity monitoring, adequate attention to group cohesion), which may compromise the efficiency of a RCT with large numbers of participants, and highlighted important new components which should be added to the core content.

The qualitative research undertaken as part of the feasibility study was evaluated in terms of criteria outlined by Tracy (2010). *Rigour* was evidenced by the diversity of the sample obtained for the semi-structured interviews, including a good balance of women who attended more or less than the minimal dose exposure and women with varying patterns of PTSD and substance use improvement during the course of the study. The data collection process was explained clearly with copies of topic guides provided. The data analysis process, in terms of how the raw data was transformed into the final themes, was illustrated step-by-step and transparently, with code checking provided by a second researcher. *Credibility* refers to the trustworthiness and plausibility of the research. This was pursued by the use of 'thick description', allowing sufficient participant quotes and the description of sufficient context in which they were said. Efforts were made to present a variety of quotes from across all the participants, presented with the selected participant attributes to illustrate transparency and representativeness. Attempts to highlight minority views were apparent. Attempts were also made to triangulate the views of the group participants with that of the facilitators and service staff, highlighting points of congruence and difference. *Coherence* can be judged by determining how well constituent parts of the study 'hang-well' together. Hopefully this is apparent to the reader in terms of with how well the earlier phase of qualitative research has fed into the later phases. The criterion of *resonance* emphasizes the importance of aesthetics; the writing up of qualitative research should be '*creative, complex, and encourage the reader to feel, think, interpret, react, or change.*' (Richardson, 2000). This is best judged by the reader and I hope I have done this justice.

The ethical conduct of the feasibility study was commended by the KCL Ethics board (see Chapter 6). In addition, I attempted to uphold a personal commitment to engage with participants through authentic and strengths-based communication and strived to uphold any promises I made. For example, two participants asked if I could provide a letter for the courts on their involvement in the study, and whilst it was outside of my remit to do this personally, I ensured that the facilitators were able to do this. Finally, *sincerity*: I have made attempts to be honest and transparent about my own biases, politics, and standpoint that were brought to bear on the research process, and which will influence the output. Particularly the delicate balancing of research-advocate roles that I navigated based on my previous professional experience and political views (Chapter 2). I kept field-notes throughout the study, and these were particularly useful for reflecting on my experience of administering the fidelity monitoring scale and interactions with the facilitators.

Caution has been taken throughout the study not to over-emphasise the implication of the quantitative data. However, with caveats aside, there were strengths in how the data were used. First, the high study retention rate and limited missing data means the quantitative data sample is representative of all participants in the study. Secondly, the intention to treat approach to the data collection, ensured that women were followed up regardless of whether they dropped out of the intervention, which is recommended practice in randomised controlled trials (Bannerjee, 2003). Thirdly, planned data analysis using a repeated measures ANOVA was appropriate for the study design, and it was applied rigorously. Particularly, with regards to understanding and exploring the requisite assumptions required to apply the statistical tests employed. Corrections were applied to account for lack of data sphericity and for the use of multiple tests. Fourth, analysis beyond those planned a-priori, were only introduced based on hypotheses formed in the qualitative data. Lastly, throughout the analysis process, advice and guidance were sought from a KCL statistician when needed.

#### **9.5.6 Phase 4 Feasibility study: limitations**

Although I was able to conduct semi-structured interviews with the majority of women participating in the study, two of the four women I was unable to interview were dissatisfied with the intervention. This was captured in the focus group and in field-notes taken during the structured

interview, however their feedback was brief and lacks the 'thick description,' requisite of rigorous qualitative research. Other aspects relating to research validity pertain to the participant checking of transcripts, as well as their validation of themes and conclusions reached from the data analysis. However, as Karnielli-Miller, Strier, & Pessach (2009) highlight, this practice in qualitative research is not unproblematic. For example, some participants may find it uncomfortable to review their transcripts in terms of how they expressed themselves and, many months down the line, may wish to re-phrase what they said, or differ in their opinion (Forbat & Henderson, 2005). This was observed in the participants' views of the facilitators expressed immediately at the end of the intervention compared to the 3-month post-intervention follow-up. Other possible limitations relate to the bias that may have been introduced when I conducted the interviews with the facilitators. Given the difficulties described with the fidelity monitoring, in retrospect it would have been more appropriate to use an alternative interviewer. However, my conducting the interviews did not appear to limit their willingness to be critical and honest, including of the dynamic in our relationship.

The quantitative study results should be cautiously interpreted, due to the caveats in the study design. First, despite evidence for improvement, this cannot be attributed to participation in the Seeking Safety intervention, due to lack of a comparison group. Women were receiving high levels of wrap-around services whilst participating in the study and lack of randomisation to a control group limits the ability to rule out these treatments as being responsible for improvements. Secondly, the sample contained nearly 50% of women reporting abstinence at baseline which limited the study's power to detect substance use reduction, especially small changes (Winhusen, Winstanley, Somoza, & Brigham, 2012). The sample size also limited the ability to carry out more sophisticated tests using repeated measures ANOVA, due to lack of power. Adding another factor variable into the repeated measures ANOVA (group dose and exposure to IPA) meant the test was potentially underpowered to detect any differences in the outcome variable of interest. Ideally, these additional analyses should have included co-variables where variables differed between the two groups, but again this was not possible due to the small sample size. In the analysis exploring the impact of new IPA on treatment outcome, the co-variables related to baseline PTSD severity and IPA recency, as well as substance use during the study, may have confounded the

association. For example, those reporting ongoing victimisation may have been those reporting more active substance use, which may explain the smaller improvements in PTSD at follow-up, given the propensity of certain substances to exacerbate PTSD symptoms (Kaplan et al., 2012). In the Women and Trauma study, women receiving Seeking Safety reporting abstinence from substances at baseline were at significantly reduced odds of experiencing IPA at follow-up compared to women who were actively using or those who were abstinent in the control group (Cohen et al., 2013).

Thirdly, 'Last Observation Carried Forward', frequently used in trials (Bell et al., 2014), was used as a simple imputation method to account for missing data. However, this method has been criticised for its biasing of results and underestimating the variability in the outcome data and assumes all data is missing at random (US National Research Council, 2010). This is an important consideration for future studies of Seeking Safety that aim to provide data for adequate sample sizes based on appropriate power calculations. In future studies with larger samples, more complex multiple imputation methods should be considered, to allow for the uncertainty about the missing data by creating several different plausible imputed data sets and appropriately combining results obtained from each of them (Sterne et al., 2009). This should be accompanied by sensitivity analysis to explore the impact of missing data (Bell et al., 2014). Because all data analysis in this study was of an exploratory nature, and there were missing data from three participants only, it was deemed unnecessary to conduct sensitivity analysis.

Finally, single group designs cannot rule out the effects of regression to the mean, which is more apparent in sample populations which have more extreme scores, compared to the general population (Davis, 1976; Marsden et al., 2010;). Women were selected based on high PTSD scores, and in a normal distribution these scores are subject to larger random error. When measured again over different time points, these scores will tend to move towards the mean, more than the scores of individuals occupying the middle range. It is a statistical phenomenon, which also increases in studies with larger measurement variable, typically found in small study samples (Marsden et al., 2010).

## 9.6 Summary and conclusions

This study is timely given the current attention within government departments, for developing TIP within mental health and substance use services in England, and the recent change to NICE guidelines for PTSD treatment. Present-focused integrated trauma-specific interventions hold promise for providing first stage safety and stabilisation work to women with substance use, including those to experiencing ongoing victimisation. By providing important coping skills to manage PTSD symptoms and wider emotional regulation, they also prepare the groundwork for second stage treatment, involving trauma memory processing, should women require it (Hermann et al., 2014; Roberts et al., 2016).

The feasibility study contributed valuable learning for future roll-out of an integrated trauma-specific intervention within substance use treatment services. The findings demonstrated that Seeking Safety was safe for participants with no major reports of deterioration in PTSD or substance use resulting from participation. Whilst the outcome results must be interpreted cautiously, there were encouraging improvements across a number of key outcome domains relating to emotional wellbeing and alcohol use. No improvements were noted for drug use, which may in part be due to the high abstinence rates at baseline and small sample sizes, meaning lack of power to detect small changes, but may also reflect realities that substance use treatment requires longer interventions. Women valued the variety of coping skills taught in the group, particularly the mind-body strategies, grounding techniques and reframing negative cognitions using compassion. The study showed that the intervention facilitators required skill and experience in working with traumatised women, along with their combined expertise of both PTSD and substance use. Therefore, appropriate care and attention must be paid by services as to how they skill their staff to implement TIP, adopt a 'safety-first' approach, and provide the wider organisational support provided for them to do that. This should be explored in the first instance before adopting integrated trauma-specific interventions such as Seeking Safety.

The study has provided answers to other key uncertainties important for consideration before proceeding to lengthier and more costly research, such as a pilot RCT. It appears feasible to recruit and retain women with PTSD symptoms into a study of Seeking Safety involving 12-

sessions. Future studies should assess feasibility of delivering a longer version, with the proposed adaptations discussed above. Women found the choice of measures acceptable, however alternative study measures for substance use are suggested. The requirement to maintain small group sizes and keep groups closed, provides challenges to future studies aiming to recruit larger sample sizes, however these implementation considerations appears important for facilitator and participant acceptability of the intervention. The administration of fidelity monitoring should be overseen by clinicians with experience of delivering Seeking Safety and certified by the intervention author. Echoing conclusions of the systematic review and stakeholder consultation, researchers should measure the impact of wider service factors that may impact on treatment outcomes for participants. Ongoing victimisation should be monitored and explored in the outcome analysis.

The ubiquity of women's experiences of IPA in childhood and adulthood, and the devastating impacts this wreaks on their lives in terms of psychological distress and substance use, cannot be ignored. This study forms an initial step in improving treatment responses for this group of women. Women in this study, reflective of those in other studies of integrated trauma-specific treatments, faced numerous challenges with interpersonal relations, co-occurring mental health problems, emotional regulation and self-awareness. Other women had head injuries as a result of their trauma resulting in difficulties with memory. On an individual practitioner level, we have a duty to help women heal these consequences of IPA. As Covington states, when we work to improve treatment for women we are working at a societal level:

"We also work on a political level when we help women to grow, develop and heal. This is a political act in a society that limits and devalues women." (Covington, 2000, p.110)

## References

- Aarons, G. A., Green, A. E., Palinkas, L. A., Self-Brown, S., Whitaker, D.,...Lutzker, J. R. (2012). Dynamic adaptation process to implement an evidence-based maltreatment intervention. *Implementation Science*, 7, 32.
- Addis, M., & Krasnow, A. (2000). A national survey of practicing psychologists' attitudes toward psychotherapy treatment manuals. *Journal of Consulting and Clinical Psychology*, 68, 331–339.
- Advisory Council on the Misuse of Drugs (2017). *Commissioning Impact on Drug Treatment: The Extent to Which Commissioning Structures, the Financial Environment and Wider Changes to Health and Social Welfare Impact on Drug Misuse Treatment and Recovery*. Retrieved from: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/642811/Final\\_Commissioning\\_report\\_5.15\\_6th\\_Sept.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/642811/Final_Commissioning_report_5.15_6th_Sept.pdf)
- Against Violence and Abuse & Solace Women's Aid. (2017). *An evaluation of the Refuge Access for All Project: Creating a psychologically informed environment in Solace Women's Aid services across five London boroughs*. Retrieved from <https://avaproject.org.uk/wp/wp-content/uploads/2017/11/Peace-of-Mind-Evaluation-for-Refuge-Acess-for-All-Project-1.pdf>
- Agenda and Against Violence and Abuse. (2017). *Mapping the Maze: Services for Women Experiencing Multiple Disadvantage in England and Wales*. Retrieved from <https://avaproject.org.uk/wp/wp-content/uploads/2017/09/Mapping-the-Maze-final-report-for-publication.pdf>
- Allen, J. P., Litten, R. Z., Fertig, J. B., & Babor, T. (1997). A review of research on the Alcohol Use Disorders Identification Test (AUDIT). *Alcoholism: Clinical & Experimental Research*, 21(4), 613- 619.
- Alvarez, R. A., Vasquez, E., Mayorga, C. C., Feaster, D. J., & Mitrani, V. B. (2006). Increasing minority research participation through community organization outreach. *Western Journal of Nursing Research*, 28, 541–560.
- Amaro, H., Chernoff, M., Brown, V., Arévalo, S., & Gatz, M. (2007). Does integrated trauma-informed substance abuse treatment increase treatment retention? *Journal of Community Psychology*, 35(7), 845-862. doi:10.1002/jcop.20185
- Amaro, H., Dai, J., Arevalo, S., Acevedo, A., Matsumoto, A., Nieves, R., & Prado, G. (2007). Effects of integrated trauma treatment on outcomes in a racially/ethnically diverse sample of women in urban community-based substance abuse treatment. *J Urban Health*, 84(4), 508-522.
- Amaro, H., Larson, M. J., Gampel, J., Richardson, E., Savage, A., & Wagler, D. (2005). Racial/Ethnic Differences in Social Vulnerability Among Women With Co-Occurring Mental Health and Substance Abuse Disorders: Implications for Treatment Services. *Journal of Community Psychology*, 33(4), 495-511. doi:<http://dx.doi.org/10.1002/jcop.20065>



- Amaro, H., McGraw, S., Larson, M. J., Lopez, L., Nieves, R., & Marshall, B. (2005). Boston Consortium of Services for Families in Recovery. *Alcoholism Treatment Quarterly*, 22(3-4), 95-119.
- Amaro, H., McGraw, S., Larson, M. J., Lopez, L., Nieves, R., & Marshall, B. (2005). Boston Consortium of Services for Families in Recovery. *Alcoholism Treatment Quarterly*, 22(3-4), 95-119. doi:10.1300/J020v22n03\_06
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition*. Arlington, VA, American Psychiatric Association, 2013
- Anderson, K. M., Renner, L. M., & Danis, F. S. (2012). Recovery: resilience and growth in the aftermath of domestic violence. *Violence Against Women*, 18(11), 1279-1299. doi:10.1177/1077801212470543
- Anderson, M. L., & Najavits, L. M. (2014). Does seeking safety reduce PTSD symptoms in women receiving physical disability compensation? *Rehabil Psychol*, 59(3), 349-353. doi:10.1037/a0036869
- Andreu, J. M., Peña, P.M., de La Cruz, M.A. (2017). Psychometric evaluation of the Posttraumatic Cognitions Inventory (PTCI) in female survivors of sexual assault *Women Health*, 57 (4), 463-477.
- Annis H. M. & Martin G (1985). *Drug-Taking Confidence Questionnaire*. *Addiction Research Foundation*; Toronto, Canada.
- Arain, M., Campbell, M. J., Cooper, C.L., Lancaster, G.A. (2010). What is a pilot or feasibility study? A review of current practice and editorial policy. *BMC Medical Research Methodology*. 10, 67.
- Arias, I. & Pape, K. T. (1999). Psychological abuse: Implications for adjustment and commitment to leave violent partners. *Violence & Victims*, 14, 55-67.
- Ashery, R. S., McAuliffe, W. E. I. (1992). Implementation issues and techniques in randomized trials of outpatient psychosocial treatments for drug abusers: recruitment of subjects. *Am J Drug Alcohol Abuse*, 18, 305-329.
- Australian Government National Health and Medical Research Council Health (2013). *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder*. Retrieved from [www.clinicalguidelines.gov.au](http://www.clinicalguidelines.gov.au)
- Back, S. E., Brady, K. T., Sonne, S. C., & Verduin, M. L. (2006). Symptom improvement in co-occurring PTSD and alcohol dependence. *J Nerv Ment Dis*, 194(9), 690-696. doi:10.1097/01.nmd.0000235794.12794.8a
- Bailey, K. (2017, March). *Clinically significant improvement in depression at follow up among survivors of domestic violence receiving advocacy within the PATH trial*. Paper presented at the World Congress of Women's Mental Health, Dublin, Ireland.
- Barber, J. P., Gallop, R., Crits-Christoph, P., Frank, A., Thase, M. E., Weiss, R. D., Gibbons, M. B. (2006). The role of therapist adherence, therapist competence, and the alliance in predicting outcome of individual drug counseling: Results from the NIDA Collaborative Cocaine Treatment Study. *Psychotherapy Research*. 16, 229-240.

- Bell, M. L., Fiero, M., Horton, N. J. & Hsu, C. H. (2014). Handling missing data in RCTs; a review of the top medical journals. *BMC Medical Research Methodology*, 14, 118. <https://doi.org/10.1186/1471-2288-14-118>
- Bergman, M. M. (2008). The Straw Men of the Qualitative-Quantitative Divide and their Influence on Mixed Methods Research. In M. M. Bergman (Ed.), *Advances in Mixed Methods Research* (pp 11-21). London: Sage.
- Berman, A. H., Bergman, H., Palmstierna, T., & Schlyter, F. (2005). Evaluation of the Drug Use Disorders Identification Test (DUDIT) in Criminal Justice and Detoxification Settings and in a Swedish Population Sample. *European Addiction Research*, 11(1).
- Bhaskar, R. (1975) *A Realist Theory of Science*. Brighton: Harvester.
- Bisson, J. I., Roberts, N. P., Andrew, M., Cooper, R., Lewis, C. (2013). Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults. *Cochrane Database of Systematic Reviews*, Issue 12. Art. No.: CD003388. DOI: 10.1002/14651858.CD003388.pub4.
- Blaikie, N (2007). *Approaches to Social Enquiry*. Cambridge: Polity.
- Blakey, J.M., Bowers, P.H. (2014). Barriers to Integrated Treatment of Substance Abuse and Trauma Among Women. *Journal of Social Work Practice in the Addictions*. 14(3), 250-72.
- Bograd, M. (1999). Strengthening Domestic Violence Theories: Intersections of Race, Class, Sexual Orientation, and Gender. *Journal of Marital and Family Therapy*, 25(3), 275-289.
- Bohn, M. J., Babor, T. F., & Kranzler, H. R. (1995). The Alcohol Use Disorders Identification Test (AUDIT): validation of a screening instrument for use in medical settings. *Journal of Studies on Alcohol*, 56(4), 423-432.
- Boyatzis, R. (1998). *Transforming qualitative information: thematic analysis and code development*. Thousand Oaks, CA: Sage.
- Brançu, M., Mann-Wrobel, M., Beckham, J. C., Wagner, H. R., Elliott, A., Robbins, A. T., . . . Runnals, J. J. (2016). Subthreshold posttraumatic stress disorder: A meta-analytic review of DSM-IV prevalence and a proposed DSM-5 approach to measurement. *Psychol Trauma*, 8(2), 222-232. doi:10.1037/tra0000078
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. doi:10.1191/1478088706qp063oa
- Breslau, N., Davis, G. C., Peterson, E. L., & Schultz, L. (1997). Psychiatric Sequelae of Posttraumatic Stress Disorder in Women. *Arch Gen Psychiatry*, 54.
- Breslau N, Davis GC, Schultz LR. (2003). Posttraumatic stress disorder and the incidence of nicotine, alcohol, and other drug disorders in persons who have experienced trauma. *Arch of General Psychiatry*. 2003;60:289-294. doi:10.1001/archpsyc.60.3.289.
- Briere, J. (1992). *Child abuse trauma: Theory and treatment of the lasting effects*. Newbury Park, CA: Sage.

- Briere, J., & Jordan, C. E. (2004). Violence against women: outcome complexity and implications for assessment and treatment. *Journal of Interpersonal Violence*, 19(11), 1252-1276. doi:10.1177/0886260504269682
- Briere, J., & Runtz, M. (1989). The Trauma Symptom Checklist (TSC-33): Early data on a new scale. *Journal of Interpersonal Violence*, 4, 151-163.
- Brotchie, J., Mayer, C., Copello, A., Kidney, R., & Waller, G. (2004). Cognitive representations in alcohol and opiate abuse: The role of core beliefs. *British Journal of Clinical Psychology*, 43, 337-342.
- Brown V. B., Melchior L. A., Waite-O'Brien N. & Huba G. J (2002). Effects of women-sensitive, long-term residential treatment on psychological functioning of diverse populations of women. *Journal of Substance Abuse Treatment*, 23: 133–144
- Brown, V. B., Najavits, L. M., Cadiz, S., Finkelstein, N., Heckman, J. P., & Rechberger, E. (2007). Implementing an evidence-based practice: Seeking Safety Group. *J Psychoactive Drugs*, 39(3), 231-240. doi:10.1080/02791072.2007.10400609
- Bryman, A. (2012). *Social Research Methods* (4th Edition). Oxford: Oxford University Press.
- Bryman, A. (2016). Integrating quantitative and qualitative research: how is it done? *Qualitative Research*, 6(1), 97-113. doi:10.1177/1468794106058877
- Brooker, C., & Durmaz, E. (2015). Mental health , sexual violence and the work of Sexual Assault Referral Centres (SARCs) in England. *Journal of Forensic and Legal Medicine*, 31, 47-51.
- Buck, D. (2016). *Local government public health budgets: A time for turning?* Retrieved from the Kings Fund website: <https://www.kingsfund.org.uk/blog/2016/08/local-government-public-health-budgets>
- Burlingame, G. M., McClendon, D. T., & Yang, C. (2018). Cohesion in group therapy: A meta-analysis. *Psychotherapy (Chic)*, 55(4), 384-398. doi:10.1037/pst0000173
- Cadiz, S., Savage, A., Bonavota, D., Hollywood, J., Butters, E., Neary, M., & Quiros, L. (2004). The Portal Project: A layered approach to integrating trauma into alcohol and other drug treatment for women. *Alcoholism Treatment Quarterly*, 22(3-4), 121-139. doi:[http://dx.doi.org/10.1300/J020v22n03\\_07](http://dx.doi.org/10.1300/J020v22n03_07)
- Calhoun, S., Messina, N., Cartier, J., & Torres, S. (2010). Implementing Gender-Responsive Treatment for Women in Prison: Client and Staff Perspectives. *Federal Probation Journal*, 74(3). Retrieved from US Courts website: <http://www.uscourts.gov/statistics-reports/publications/federal-probation-journal>
- Campbell, R., Dworkin, E., & Cabral, G. (2009). An ecological model of the impact of sexual assault on women's mental health. 10, 225-246 doi: 10.1177/1524838009334456.
- Capezza, N., & Najavits, L. (2012). Rates of trauma-informed counseling at substance abuse treatment facilities: Reports from over 10,000 programs. *Psychiatric Services*, 63, 390-394. doi:10.1176/

- Carvalho, M. L., Honeycutt, S., Escoffery, C., Glanz, K., Sabbs, D., Kegler, M. C. (2013). Balancing fidelity and adaptation: implementing evidence-based chronic disease prevention programs. *Journal of Public Health Management and Practice*, 19(4), 348–56.
- Castilho, P., Pinto-Gouveia, J., & Duarte, J. (2017). Two forms of self-criticism mediate differently the shame-psychopathological symptoms link. *Psychological Psychotherapy*, 90(1), 44–54. doi:10.1111/papt.12094
- Cecero, J. J., Fenton, L. R., Nich, C., Frankforter, T. L., & Carroll, K. M. (2001). Focus on the Therapeutic Alliance: The Psychometric Properties of Six Measures Across Three Treatments. *Psychotherapy*, 38 (1), 1-11.
- Chesney, S.A. & Gordon, N.S. (2016). Profiles of emotion regulation: understanding regulatory patterns and the implications for posttraumatic stress. *Cognition and Emotion*, pp. 1-9, doi: [10.1080/02699931.2015.1126555](https://doi.org/10.1080/02699931.2015.1126555)
- Chemaly, S. L. (2018). *Rage Becomes Her*. New York: Atria Books.
- Chilcoat, H., & Breslau, N. (1998). Investigations of Causal Pathways between PTSD and Drug Use Disorder. *Addictive Behaviors*, 23(6), 827-840.
- Cloitre, M., Courtois, C. A., Charuvastra, A., Carapezza, R., Stolbach, B. C., & Green, B. L. (2011). Treatment of complex PTSD: Results of the ISTSS expert clinician survey on best practices. *Journal of Traumatic Stress*, 24(6), 615-627. doi:10.1002/jts.20697
- Cloitre, M., Koenen, K. C., Cohen, L. R., & Han, H. (2002). Skills training in affective and interpersonal regulation followed by exposure: A phase-based treatment for PTSD related to child abuse. *Journal of Consulting and Clinical Psychology*, 70, 1067-1074.
- Cloitre, M., Petkova, E., Su, Z., & Weiss, B. (2016). Patient characteristics as a moderator of post-traumatic stress disorder treatment outcome: combining symptom burden and strengths. *BJPsych Open*, 2(2), 101-106. doi:10.1192/bjpo.bp.115.000745
- Cloitre, M., Stolbach, B. C., Herman, J. L., van der Kolk, B., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: childhood and adult cumulative trauma as predictors of symptom complexity. *J Trauma Stress*, 22(5), 399-408. doi:10.1002/jts.20444
- Cloitre, M., Stovall-McClough, K. C., Miranda, R., & Chemtob, C. M. (2004). Therapeutic alliance, negative mood regulation, and treatment outcome in child abuse-related posttraumatic stress disorder. *J Consult Clin Psychol*, 72(3), 411-416. doi:10.1037/0022-006X.72.3.411
- Clinical Guidelines on Drug Use and Dependence Update 2017 Independent Expert Working Group (2017). *Drug use and dependence: UK guidelines on clinical management*. London: Department of Health.
- Cocozza, J. J., Jackson, E. W., Hennigan, K., Morrissey, J. P., Reed, B. G., Fallot, R., & Banks, S. (2005). Outcomes for women with co-occurring disorders and trauma: Program-level effects. *Journal of Substance Abuse Treatment*, 28(2), 109-119. doi:<http://dx.doi.org/10.1016/j.jsat.2004.08.010>
- Coffey, S. F., Stasiewicz, P. R., Hughes, P. M., & Brimo, M. L. (2006). Trauma-focused imaginal exposure for individuals with comorbid posttraumatic stress disorder and alcohol

- dependence: revealing mechanisms of alcohol craving in a cue reactivity paradigm. *Psychological Addictive Behavior*, 20(4), 425-435. doi:10.1037/0893-164X.20.4.425
- Cohen, L. R., Field, C., Campbell, A. N. C., & Hien D. A. (2013). Intimate partner violence outcomes in women with PTSD and substance use: A secondary analysis of NIDA clinical trials network "Women and Trauma" multi-site study. *Addictive Behaviors*, 38(7), 2325-2332. <https://doi.org/10.1016/j.addbeh.2013.03.006>
- Cohen, S., & T.A., W. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, 98, 310-357. doi:10.1037/0033-2909.98.2.310
- Coker, A. L., Smith, P. H., Thompson, M. P., McKeown, R. E., Bethea, L., & Davis, K. E. (2002). Social support protects against the negative effects of partner violence on mental health. *Journal of Women's Health and Gender-Based Medicine*, 11, 465-476.
- Comfort, M., Zanis, D., Whitely, M., Kelly-Tyler, A., & Kaltenbach, K. (1999). Assessing the needs of substance abusing women. Psychometric data on the psychosocial history. *Journal of Substance Abuse Treatment*, 17(1-2), 79-83.
- Constantino, R., Kim, Y., & Crane, P. A. (2005). Effects of a social support intervention on health outcomes in residents of a domestic violence shelter: a pilot study. *Issues Mental Health Nursing*, 26(6), 575-590. doi:10.1080/01612840590959416
- Copello, A., Orford, J., Hodgson, R. & Toben, G. (2009). *Social and Behaviour and Network Therapy for Alcohol Problems*. Abingdon, UK: Routledge.
- Courtois, C. A., & Ford, J. D. (2009). *Treating complex traumatic stress disorders: An evidence-based guide*. New York, NY: Guilford Press.
- Covington, S. S. (2000). Helping Women Recover. *Alcoholism Treatment Quarterly*, 18(3), 99-111. doi:10.1300/J020v18n03\_09
- Covington, S. S. (2016). *Beyond Trauma: A Healing Journey for Women, Facilitator Guide* (2<sup>nd</sup> edition). Center City, MN: Hazelden Publishing.
- Covington, S. S., & Bloom, S. (2007). Gender Responsive Treatment and Services in Correctional Settings, . *Women & Therapy*, 29(3-4), 9-33. doi:10.1300/J015v29n03\_02
- Covington, S. S., & Surrey, J. (1997). The Relational Model of Women's Psychological Development: Implications for Substance Abuse In R. Wilsnack, W. & S. Wilsnack, C. (Eds.), *Gender and alcohol: individual and societal perspectives* (pp. 335-351). New Brunswick, N.J.: Rutgers Center of Alcohol Studies.
- Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2008). Developing and evaluating complex interventions: the new Medical Research Council guidance. *British Medical Journal*, 337(a1655). doi:<http://dx.doi.org/10.1136/bmj.a1655>
- Creswell, J. W., & Plano Clark, V. L. (2007). *Design and Conducting Mixed Methods Research* (1st edition). California: Sage.
- Critical Appraisal Skills Programme (2018). CASP Qualitative Checklist (online). Retrieved from [www.casp-uk.net](http://www.casp-uk.net)

- Crowe, T. P., & Grenyer, B. F. (2008). Is therapist alliance or whole group cohesion more influential in group psychotherapy outcomes? *Clin Psychol Psychother*, 15(4), 239-246. doi:10.1002/cpp.583
- Cummings A. M., Gallop R. J. & Greenfield S. F. (2010). Self-efficacy and substance use outcomes for women in single gender versus mixed-gender group treatment. *Journal of Groups in Addiction & Recovery* 5: 4–16.
- Cuppige, J., Baird, K., Gibson, J., Booth, R., & Hevey, D. (2018). Compassion focused therapy: Exploring effectiveness with a transdiagnostic group and potential processes of change. *British Journal of Clinical Psychology*, 57(2), 204-254.
- Cuppige, C., & Russell, D. (1987). The Provisions of Social Relationships and Adaption to Stress. *Advances in Personal Relationships*, 1, 37-67.
- Daepfen, J. B., Yersin, B., Landry, U., Pecoud, A., & Decrey, H. (2000). Reliability and validity of the Alcohol Use Disorders Identification Test (AUDIT) imbedded within a general health risk screening questionnaire: Results of a survey in 332 primary care patients. *Alcoholism: Clinical and Experimental Research*, 24(5), 659-665.
- Dansky, B., Saladin, M., Brady, K., Kilpatrick, D., & Resnick, H. (1995). Prevalence of victimization and posttraumatic stress disorder among women with substance use disorders: a comparison of telephone and in-person assessment samples. *International Journal of Addiction*, 30, 1079-1099
- Dalai Lama (*Bhiksu Tenzin Gyatsu*). (2001). *Dalai Lama's Little Book of Compassion*. UK: The Fourteenth Dalai Lama & Thorsons.
- Davies, R., Seamam, S., Burlingame, G. M., & Layne, C. M. (2002). *Selecting adolescents for group-based trauma treatment using a self-report questionnaire*. Paper presented at the annual meeting of the American Group Psychotherapy Association, New Orleans, Louisiana.
- Davis, C. E. (1976). The effect of regression to the mean in epidemiologic and clinical studies. *Am J Epidemiol*. 104(5), 493-8
- Davis, L., Uezato, A., Newell, J. M., & Frazier, E. (2008). Major depression and comorbid substance use disorders. *Current Opinion in Psychiatry*, 21, 14-18.
- Day, E., Copello, A., Seddon, J. L., Christie, M., Bamber, D., Powell, C., . . . Freemantle, N. (2018). A pilot feasibility randomised controlled trial of an adjunct brief social network intervention in opiate substitution treatment services. *BMC Psychiatry*, 18(1), 8. doi:10.1186/s12888-018-1600-7
- Day, E., & Mitcheson, L. (2017). Psychosocial interventions in opiate substitution treatment services: does the evidence provide a case for optimism or nihilism? *Addiction*, 112(8), 1329-1336. doi:10.1111/add.13644
- Deady, M. (2009) A Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings, *For the Network of Alcohol & other Drug Agencies (NADA) as part of the Drug and Alcohol and Mental Health Information Management Project*



- Department of Health. (2017). *Drug Misuse and Dependence: UK Guidelines on clinical management*. Retrieved from <https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management>
- Department of Health and Social Care and Agenda. (2018). *The Women's Mental Health Taskforce, Final Report*. Retrieved from [https://weareagenda.org/wp-content/uploads/2018/12/The\\_Womens\\_Mental\\_Health\\_Taskforce\\_-\\_final\\_report1.pdf](https://weareagenda.org/wp-content/uploads/2018/12/The_Womens_Mental_Health_Taskforce_-_final_report1.pdf)
- Desai, R. A., Harpaz-Rotem, I., Najavits, L. M., & Rosenheck, R. A. (2008). Impact of the Seeking Safety Program on Clinical Outcomes Among Homeless Female Veterans With Psychiatric Disorders. *Psychiatric Services*, 59(9).
- Devries, K., Mak, J., Loraine, J., Child, J., Falder, G., & Petzold, M. (2013). Intimate partner violence and incident depressive symptoms and suicide attempts: a systematic review of longitudinal studies. *PLoS Med*, 10.
- Dick, A. M., Niles, B. L., Street, A. E., DiMartino, D. M., & Mitchell, K. S. (2014). Examining mechanisms of change in a yoga intervention for women: The influence of mindfulness, psychological flexibility, and emotion regulation on PTSD symptoms. *Journal of clinical psychology*, 70(12), 1170-1182. doi:<http://dx.doi.org/10.1002/jclp.22104>
- Dickinson, H., Allen, K., Alcock, P., Macmillan, R. & Glasby, J. 2012. *The role of the third sector in delivering social care*. London: National Institute for Health Research.
- Domestic Abuse Intervention Programme (1984). Power and Control Wheel. Retrieved from <https://www.theduluthmodel.org/wheels/>
- Domino, M., Morrissey, J. P., Nadlicki-Patterson, T., & Chung, S. (2005). Service costs for women with co-occurring disorders and trauma. *Journal of Substance Abuse Treatment*, 28(2), 135-143. doi:<http://dx.doi.org/10.1016/j.jsat.2004.08.011>
- Dorrington, S., Zavos, H., Ball, H., McGuffin, P., Rijdsdijk, F., Siribaddana, S., . . . Hotopf, M. (2014). Trauma, post-traumatic stress disorder and psychiatric disorders in a middle-income setting: prevalence and comorbidity. *Br J Psychiatry*, 205(5), 383-389. doi:10.1192/bjp.bp.113.141796
- Drugscope & Against Violence and Abuse (2013). Improving services for women involved in prostitution and substance use, policy briefing. Retrieved from [https://avaproject.org.uk/wp/wp-content/uploads/2016/03/Challenge-of-change\\_policy-briefing.pdf](https://avaproject.org.uk/wp/wp-content/uploads/2016/03/Challenge-of-change_policy-briefing.pdf)
- Dutton, M., Green, B., Kaltman, S., Roesch, D., Zeffiro, T., & Krause, E. (2006). Intimate partner violence, PTSD, and adverse health outcomes. *Journal of Interpersonal Violence*, 21, 995-968.
- Drummond, C. (2017). Cuts to addiction services are a false economy. *British Medical Journal*, 357, j2704, doi: 10.1136/bmj.j2704
- Drummond, C., Day, E. & Strang, J. (2017) Return failing drug and alcohol detoxification services to NHS control, *BMJ Opinion*. Retrieved from: <https://blogs.bmj.com/bmj/2017/11/30/return-failing-drug-and-alcohol-detoxification-services-to-nhs-control/>

- Eby, K. K. (2004). Exploring the stressors of low-income women with abusive partners: Understanding their needs and developing effective community responses. *Journal of Family Violence*, 19(4), 221–232. doi:10.1023/B:JOFV.0000032632.59865.8e
- Effective Public Health Practice Project (EPHPP). (1998). Quality Assessment Tool For Quantitative Studies. Retrieved from [https://merst.ca/wp-content/uploads/2018/02/quality-assessment-tool\\_2010.pdf](https://merst.ca/wp-content/uploads/2018/02/quality-assessment-tool_2010.pdf)
- Ehlers, A., Bisson, J., Clark, D. M., Creamer, M., Pilling, S., Richards, D., . . . Yule, W. (2010). Do all psychological treatments really work the same in posttraumatic stress disorder? *Clin Psychol Rev*, 30(2), 269-276. doi:10.1016/j.cpr.2009.12.001
- Ehlers, A., Clark, D.M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research & Therapy*, 38(4), 319-45.
- Ehlers, A., Clark, D., McManus, F., & Fennell, M. (2005). Cognitive therapy for post-traumatic stress disorder: Development and evaluation. *Behaviour Research and Therapy. Behaviour Research & Therapy*, 43, 413-431.
- Ehlers, A., Grey, N., Wild, J., Stott, R., Liness, S., Deale, A., . . . Clark, D. M. (2013). Implementation of cognitive therapy for PTSD in routine clinical care: effectiveness and moderators of outcome in a consecutive sample. *Behav Res Ther*, 51(11), 742-752. doi:10.1016/j.brat.2013.08.006
- El-Bassel, N., Gilbert, L., Wu, E., Go, H., & Hill, J. (2005). Relationship between drug abuse and intimate partner violence: a longitudinal study among women receiving methadone. *Am J Public Health*, 95(3), 465-470. doi:10.2105/AJPH.2003.023200
- Eldridge, S. M., Lancaster, G. A., Campbell, M. J., Thabane, L., Hopewell, S., Coleman, C. L., & Bond, C. M. (2016). Defining Feasibility and Pilot Studies in Preparation for Randomised Controlled Trials: Development of a Conceptual Framework. *PLoS ONE*, 11(3), e0150205. doi:10.1371/journal.pone.0150205
- Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, 33(4), 461-477. doi:10.1002/jcop.20063
- Elliott, D.S. & Mihalic, S. (2004) Issues in disseminating and replicating effective prevention programs. *Prevention Science*, 5(1), 47-52.
- Emerson, D. (2014). Trauma-sensitive yoga as an adjunct mental health treatment in group therapy for survivors of domestic violence: a feasibility study. *Complementary therapies in clinical practice*, 20(3), 152-158. doi:<http://dx.doi.org/10.1016/j.ctcp.2014.04.003>
- Etherington, N. A. & Baker, L. L. (2017). *Links between the Maltreatment of Girls and Later Victimization on or Use of Violence*. Retrieved from VAW Learning network website: [http://www.vawlearningnetwork.ca/sites/vawlearningnetwork.ca/files/PHAC\\_Girls\\_Report\\_ONLINE.pdf](http://www.vawlearningnetwork.ca/sites/vawlearningnetwork.ca/files/PHAC_Girls_Report_ONLINE.pdf)
- European Monitoring Centre for Drugs and Drug Addiction. (2016). *How can contingency management support treatment for substance use disorders? A systematic review*. EMCDDA Papers, Publications Office of the European Union, Luxembourg.



- Fallot, R. D., & Harris, M. (2002). The trauma recovery and empowerment model (TREM): Conceptual and practical issues in a group intervention for women. *Community Mental Health Journal*, 38(6), 475-485. doi:10.1023/A:1020880101769
- Fallot, R. D., & Harris, M. (2004). Integrated Trauma Services Teams for Women Survivors with Alcohol and Other Drug Problems and Co-Occurring Mental Disorders. 3-4.
- Fallot, R. & Harris M. (2014). Creating Cultures of Trauma Informed Care: Program Fidelity Scale. (Copy available from authors)
- Fallot, R., McHugo, G., Harris, M., & Xie, H. (2011). The Trauma Recovery and Empowerment Model: A Quasi-Experimental Effectiveness Study. *J Dual Diagn*, 7(1), 74-89. doi:10.1080/15504263.2011.566056
- Fals-Stewart, W., O'Farrell, T. J., Freitas, T. T., McFarlin, S. K., & Rutigliano, P. (2000). The timeline followback reports of psychoactive substance use by drug-abusing patients: Psychometric properties. *Journal of Consulting and Clinical Psychology*, 68(1), 134-144.
- Fenton, L. R., Cecero, J. J., Nich, C., Frankforter, T. L., & Carroll, K. M. (2001). Perspective Is Everything: The Predictive Validity of Six Working Alliance Instruments. *Journal of Psychotherapy Practice and Research*, 10(4), 262-268.
- Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. *International Journal of Qualitative Methods*, 5(1), 5-11.
- Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry*, 55(4), 530-541. <https://doi.org/10.1111/j.1939-0025.1985.tb02703.x>
- Flanagan, J. C., Jaquier Erard, V., Overstreet, N., Swan, S. C., & Sullivan, T. P. (2014). The mediating role of avoidance coping between IPV victimization, mental health, and substance abuse among women experiencing bidirectional IPV. *Psychiatry Research*, 220(1-2), 391-396
- Flatly, J. (2017). *Domestic abuse in England and Wales, year ending March 2017* (Statistical Bulletin). Retrieved from Office for National Statistics website: <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwales/yearendingmarch2017#how-prevalent-is-domestic-abuse>
- Fletcher, A., Jamal, F., Moore, G., Evans, R. E., Murphy, S., & Bonell, C. (2016). Realist complex intervention science: Applying realist principles across all phases of the Medical Research Council framework for developing and evaluating complex interventions. *Evaluation*, 22(3), 286-303. doi:10.1177/1356389016652743
- Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, 55(4), 316-340. doi:10.1037/pst0000172
- Foa, E. B., Cashman, L., Jaycox, L., & Perry, K. (1997). The Validation of a Self-Report Measure of Posttraumatic Stress Disorder: The Posttraumatic Diagnostic Scale. *Psychological Assessment*, 9(4), 445-451.

- Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). *Prolonged Exposure Therapy for PTSD: Therapist Guide Emotional processing of traumatic experiences (Treatments That Work)*. New York: Oxford University Press.
- Foa, E. B., & Williams, M. T. (2010). Methodology of a randomized double-blind clinical trial for comorbid posttraumatic stress disorder and alcohol dependence. *Ment Health Subst Use*, 3(2), 131-147. doi:10.1080/17523281003738661
- Foa, E. B., Yuskow, D. A., McLean, C. P., Suvak, M. K., Bux, D. A., Jr., Oslin, D., . . . Volpicelli, J. (2013). Concurrent naltrexone and prolonged exposure therapy for patients with comorbid alcohol dependence and PTSD: a randomized clinical trial. *JAMA*, 310(5), 488-495. doi:10.1001/jama.2013.8268
- Forbat, L., & Henderson, J. (2005). Theoretical and practical reflections on sharing transcripts with participants, *Qualitative Health Research*, 15, 1114-1128.
- Ford, J. D. (1999). Disorders of extreme stress following war-zone military trauma: Associated features of posttraumatic stress disorder or comorbid but distinct syndromes? *Journal of Consulting and Clinical Psychology*, 67, 3-12, doi:10.1037/0022-006x.67.1.3
- Ford, J. D., Courtois, C. A., Steele, K., Van der Hart, O., & Nijenhuis, E. R. S. (2005). Treatment of complex posttraumatic self-dysregulation. *Journal of Traumatic Stress*, 18, 437-447, doi:10.1002/jts.20051
- Ford, J. D. (2009). Neurobiological and developmental research: Clinical implications. In C. A. Courtois & J. D. Ford (Eds.). *Treating complex traumatic stress disorders: An evidence based guide* (pp. 31-58). New York: Guilford Press
- Ford, J., & Russo, E. M. (2006). Trauma-Focused, Present-Centered, Emotional Self-Regulation Approach to Integrated Treatment for Posttraumatic Stress and Addiction: Trauma Adaptive Recovery Group Education and Therapy (TARGET). *American Journal of Psychotherapy*, 60(4), 335-355.
- Ford-Gilboe, M., Wathen, C. N., Varcoe, C., MacMillan, H. L., Scott-Storey, K., Mantler, T., . . . Perrin, N. (2016). Development of a brief measure of intimate partner violence experiences: the Composite Abuse Scale (Revised)-Short Form (CASR-SF). *BMJ Open*, 6(12), e012824. doi:10.1136/
- Fowler, D. (2007). The extent of substance use problems among women partner abuse survivors residing in a domestic violence shelter. *Family and Community Health, Supplement*, 1, S106- S108.
- Fowler, D. N., & Faulkner, M. (2011). Interventions targeting substance abuse among women survivors of intimate partner abuse: A meta-analysis. *Journal of Substance Abuse Treatment*, 41(4), 386-398. doi:10.1016/j.jsat.2011.06.001
- Frisman, L., Ford, J., Lin, H.-J., Mallon, S., & Chang, R. (2008). Outcomes of Trauma Treatment Using the TARGET Model. *Journal of Groups in Addiction & Recovery*, 3(3-4), 285-303. doi:10.1080/15560350802424910
- Gadd, D., Farrall, S., Dallimore, D., & Lombard, N. (2002) *Domestic Abuse Against Men in Scotland* (Report produced for the Scottish Executive Central Research Unit). Retrieved

- Galaif, E. R., Stein, J. A., Newcomb, M. D., & Bernstein, D. P. (2001). Gender differences in the prediction of problem alcohol use in adulthood: Exploring the influence of family factors and childhood maltreatment. *Journal of Studies on Alcohol*, 62(4), 486-493.
- Galvani, S. A. (2007). Safety in numbers? Tackling domestic abuse in couples and network therapies. *Drug Alcohol Rev*, 26(2), 175-181. doi:10.1080/09595230601146694
- Galvani, S. A. (2009). Safety first? The impact of domestic abuse on women's treatment experience. *Journal of Substance Use*, 11(6), 395-407. doi:10.1080/14659890600708225
- Galvani, S., & Humphreys, C. (2007). *The impact of violence and abuse on engagement and retention rates for women in substance use treatment*. Retrieved from <http://www.ccrm.org.uk/images/docs/7.3aimpactofviolenceonengagementandretentionrates.pdf>
- Gaston, L., & Marmar, C. R. (1994). The California Psychotherapy Alliance scales. In A. O. Horvath & L. S. Greenberg (Eds.), *The Working Alliance: Theory, Research and Practice* (pp. 85-108). New York: John Wiley & Sons, Inc.
- Gatenby, B., & Humphries, M. (2000). Feminist participatory action research: Methodological and ethical issues. *Women's Studies International Forum*, 23(1), 89-105.
- Gatz, M., Brown, V., Hennigan, K., Rechberger, E., O'Keefe, M., Rose, T., & Bjelajac, P. (2007). Effectiveness of an integrated, trauma-informed approach to treating women with co-occurring disorders and histories of trauma: The Los Angeles site experience. *Journal of Community Psychology*, 35(7), 863-878. doi:10.1002/jcop.20186
- Ghee, A. C., Bolling, L. C., & Johnson, C. S. (2009). The efficacy of a condensed Seeking Safety intervention for women in residential chemical dependence treatment at 30 days posttreatment. *J Child Sex Abus*, 18(5), 475-488. doi:10.1080/10538710903183287
- Ghee, A. C., Johnson, C. S., Burlew, A. K., & Boiling, L. C. (2009a). Enhancing retention through a condensed trauma-integrated intervention for women with chemical dependence. *North American Journal of Psychology*, 11(1), 157-172.
- Goicolea, I., Vives-Cases, C., Hurtig, A. K., Marchal, B., Briones-Vozmediano, E., Otero-Garcia, L., . . . San Sebastian, M. (2015). Mechanisms that Trigger a Good Health-Care Response to Intimate Partner Violence in Spain. Combining Realist Evaluation and Qualitative Comparative Analysis Approaches. *PLoS ONE*, 10(8), e0135167. doi:10.1371/journal.pone.0135167
- Goldsmith, R. E., Gerhart, J. I., Chesney, S. A., Burns, J. W., Kleinman, B., & Hood, M. M. (2014). Mindfulness-based stress reduction for posttraumatic stress symptoms: building acceptance and decreasing shame. *J Evid Based Complementary Altern Med*, 19(4), 227-234.
- Gilbert, L., El-Bassel, N., & Manual, J. (2005). *Women's Wellness Treatment Manual*. Social Intervention Group, Columbia University.

- Gilbert, L., El-Bassel, N., Manuel, J., Wu, E., Go, H., Golder, S., . . . Sanders, G. (2006). An integrated relapse prevention and relationship safety intervention for women on methadone: testing short-term effects on intimate partner violence and substance use. *Violence and victims*, 21(5), 657-672.
- Gilbert, A.R., Morrissey, J.P. & Domino, M.E. (2011) Service Utilization Patterns as Predictors of Response to Trauma-Informed Integrated Treatment for Women With Co-occurring Disorders, *Journal of Dual Diagnosis*, 7:3, 117-129, doi:10.1080/15504263.2011.592411
- Gilbody, S., Richards, D., & Barkham, M. (2007). Diagnosing depression in primary care using self-completed instruments: UK validation of PHQ-9 and CORE-OM. *British Journal of General Practice*, 57, 650-652.
- Gilchrist, G., Blázquez, A., & Torrens, M. (2012). Exploring the relationship between intimate partner violence, childhood abuse and psychiatric disorders among female drug users in Barcelona. *Advances in Dual Diagnosis*, 5(2), 46-58. doi:10.1108/17570971211241895
- Gilchrist, G., Gruer, L., & Atkinson, J. (2005). Comparison of drug use and psychiatric morbidity between prostitute and non-prostitute female drug users in Glasgow, Scotland. *Addictive Behaviors*, 30(5), 1019-23.
- Gilchrist, G., Singleton, N., Donmall, M., & Jones, A. (2015). Prevalence and factors associated with sex trading in the year prior to entering treatment for drug misuse in England. *Drug Alcohol Depend*, 152, 116-122. doi:10.1016/j.drugalcdep.2015.04.017
- Godlaski, T. M., Butler, L., Heron, M., Debord, S., & Cauvin, L. (2009). A qualitative exploration of engagement among rural women entering substance user treatment. *Substance Use & Misuse*, 44: 62–83.
- Gold, S.R., Milan, L.D., Mayall, A., & Johnson, A.E. (1994). A cross-validation study of the Trauma Symptom Checklist: The role of mediating variables. *Journal of Interpersonal Violence*, 9, 12-26.
- Goldsmith, R. E., Gerhart, J. I., Chesney, S. A., Burns, J. W., Kleinman, B., & Hood, M. M. (2014). Mindfulness-based stress reduction for posttraumatic stress symptoms: building acceptance and decreasing shame. *J Evid Based Complementary Altern Med*, 19(4), 227-234. doi:10.1177/2156587214533703
- Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of Psychopathology and Behavioral Assessment*, 26, 41–54. doi: [10.1023/B:JOBA.0000007455.08539.94](https://doi.org/10.1023/B:JOBA.0000007455.08539.94).
- Grauerholz, L. (2000). An ecological approach to understanding sexual revictimization: Linking personal, interpersonal, and sociocultural factors and processes. *Child Maltreatment*, 5(1), 5–17
- Greenberg, R. (2016). The rebirth of psychosocial importance in a drug-filled world. . *American Psychologist*, 71, 781-791.

- Greenfield, S. F., Cummings A. M., Kuper L. E., Wigerson S. B. & Koro-Ljuunberg M (2013). A qualitative analysis of women's experiences in single-gender versus mixed-gender substance abuse group therapy. *Substance Use & Misuse*, 48, 750–760.
- Greenfield, S. F., Sugarman, D. E., Freid, C. M., Bailey, G. L., Crisafulli, M. A., Kaufman, J. S., . . . Fitzmaurice, G. M. (2014). Group therapy for women with substance use disorders: results from the Women's Recovery Group Study. *Drug Alcohol Depend*, 142, 245-253. doi:10.1016/j.drugalcdep.2014.06.035
- Greenfield, S. F., Kolodziej, M., Sugarman, D., Muenz, L., Vagge, L., He, D., & Weiss, R. (2002). History of abuse and drinking outcomes following inpatient treatment: a prospective study. *Drug and Alcohol Dependence*, 227-234.
- Grella, C. (2007). From Generic to Gender-Responsive Treatment Changes in Social Policies, Treatment Services, and Outcomes of Women in Substance Abuse Treatment. *Journal of psychoactive drugs*. 40, 327-343.
- Guba, E. G., & Lincoln, Y. S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 191-216). Thousand Oaks, CA: Sage.
- Guerrero, E. G., Marsh, J. C., Duan, L., Oh, C., Perron, B., & Lee, B. (2013). Disparities in completion of substance abuse treatment between and within racial and ethnic groups. *Health Serv Res*, 48(4), 1450-1467. doi:10.1111/1475-6773.12031
- Gutierrez, S. E., & Van Puymbroeck, C. (2006). Childhood and adult violence in the lives of women who misuse substances. *Aggression and Violent Behavior*, 11(5), 497-513. doi:<http://dx.doi.org/10.1016/j.avb.2006.01.010>
- Hammersley, R., Dalgarno, P., McCollum, S., Reid, M., Strike, Y. Smith, A... Liddell, D. (2016). Trauma in the childhood stories of people who have injected drugs, *Addiction Research & Theory*, 24:2, 135-151, doi: [10.3109/16066359.2015.1093120](https://doi.org/10.3109/16066359.2015.1093120)
- Harris, M. (1998). *Trauma Recovery and Empowerment (TREM): A Clinician's guide for working with women in groups*. New York: The Free Press.
- Harris, M., & Fallot, R. D. (2001). Designing trauma-informed addictions services. In M. Harris & R. D. Fallot (Eds.), *Using Trauma Theory to Design Service Systems. New Directions for Mental Health Services Series* (pp. 57-73). San Francisco, CA: Jossey-Bass.
- Harris, M., Fallot, R. D., & Berley, R. W. (2005). Qualitative interviews on substance abuse relapse and prevention among female trauma survivors. *Psychiatric Services*, 56(10), 1292-1296. doi:<http://dx.doi.org/10.1176/appi.ps.56.10.1292>
- Hatcher, R. L., & Gillaspay, J. A. (2006). Development and validation of a revised short version of the working alliance inventory. *Psychotherapy Research*, 16(1), 12-25. doi:10.1080/10503300500352500
- Heckman, J. P., Hutchins, F. A., Thom, J. C., & Russell, L. A. (2004). Allies: Integrating women's alcohol, drug, mental health and trauma treatment in a county system. *Alcoholism Treatment Quarterly*, 22(3-4), 161-180. doi:[http://dx.doi.org/10.1300/J020v22n03\\_09](http://dx.doi.org/10.1300/J020v22n03_09)

- Hegarty, K. L., Bush, R., & Sheehan, M. (2005). The Composite Abuse Scale: Further Development and Assessment of Reliability and Validity of a Multi-dimensional Partner Abuse Measure in Clinical Settings. *Violence and victims*, 20(5), 529-547.
- Heise, L. (1998). Violence Against Women. An Integrated, Ecological Framework. *Violence Against Women*, 4(3), 262-290.
- Herman, J. 1998. Recovery from psychological trauma. *Psychiatry and Clinical Neurosciences* 52:51 S98-S103.
- Herman, J. (2001). *Trauma and Recovery: The aftermath of violence from domestic abuse to political terror*. (2<sup>nd</sup> edition). London: Pandora
- Hermann, B., Hamblen, J., Bernardy, N., & Schnurr, P. (2014). Evaluating the evidence for PTSD-SUD Treatment. In P. Ouimette & J. Read (Eds.), *Trauma and Substance Abuse: Causes, Consequences, and Treatment of Co-morbid Disorders* (Second Edition ed., pp. 233-252). Washington, DC: American Psychological Association.
- Hien, D. A., Campbell, A. N., Ruglass, L. M., Hu, M. C., & Killeen, T. (2010). The role of alcohol misuse in PTSD outcomes for women in community treatment: a secondary analysis of NIDA's Women and Trauma Study. *Drug Alcohol Depend*, 111(1-2), 114-119. doi:10.1016/j.drugalcdep.2010.04.011
- Hien, D. A., Campbell, A. N., Ruglass, L. M., Saavedra, L., Mathews, A. G., Kiriakos, G., & Morgan-Lopez, A. (2015). Maximizing Effectiveness Trials in PTSD and SUD Through Secondary Analysis: Benefits and Limitations Using the National Institute on Drug Abuse Clinical Trials Network "Women and Trauma" Study as a Case Example. *J Subst Abuse Treat*, 56, 23-33. doi:10.1016/j.jsat.2015.04.001
- Hien, D. A., Cohen, L. R., & Campbell, A. N. (2009). Methodological Innovation to Increase the Utility and Efficiency of Psychotherapy Research for Patients with Co-occurring Mental Health and Substance Use Disorders. *Prof Psychol Res Pr*, 40(5), 502-509. doi:10.1037/a0014966
- Hien, D., Cohen, L. R., Miele, G. M., Litt, L. C., & Capstick, C. (2004). Promising treatments for women with comorbid PTSD and substance use disorders. *American Journal of Psychiatry*, 161(8), 1426-1432. doi:10.1176/appi.ajp.161.8.1426
- Hien, D. A., Jiang, H., Campbell, A. N., Hu, M. C., Miele, G. M., Cohen, L. R., . . . Nunes, E. V. (2010). Do treatment improvements in PTSD severity affect substance use outcomes? A secondary analysis from a randomized clinical trial in NIDA's Clinical Trials Network. *Am J Psychiatry*, 167(1), 95-101. doi:10.1176/appi.ajp.2009.09091261
- Hien, D. A., Lopez-Castro, T., Papini, S., Gorman, B., & Ruglass, L. M. (2017). Emotion dysregulation moderates the effect of cognitive behavior therapy with prolonged exposure for co-occurring PTSD and substance use disorders. [References]. *Journal of Anxiety Disorders*, 52, 53-61.
- Hien, D. A., Wells, E. A., & Brigham, G. S. (2009). Multi-site randomized trial of behavioral interventions for women with co-occurring PTSD and substance use disorders. *J Consult Clin Psychology*, 77(4), 607-619. doi:10.1037/a0016227.Multi-site

- Hien, D. (2009). Trauma, Posttraumatic Stress Disorder, and Addiction among Women. In K. T. Brady, S. E. Back, & S. F. Greenfield (Eds.), *Women and Addiction: a comprehensive handbook* (pp. 242-256). New York: Guildford Press.
- Higginbottom, G., & Liamputtong, P. (2015). What is Participatory Research? Why Do it? In G. Higginbottom, & P. Liamputtong (Eds.), *Participatory Qualitative Research Methodologies in Health* (pp 1-21). London: Sage.
- Hobden, B., Bryant, J., Carey, M., Baker, A., Farrell, M., Oldmeadow, C., . . . Sanson-Fisher, R. (2018). Finding the optimal treatment model: A systematic review of treatment for co-occurring alcohol misuse and depression. *Australian and New Zealand Journal of Psychiatry*, 52(8), 737-750.
- Hodgins, D. C., & el-Guebaly, N. (1992). More data on the Addiction Severity Index. Reliability and validity with the mentally ill substance abuser. *J Nerv Ment Dis*, 180(3), 197-201.
- Holly, J. & Horvath, M. A. H. (2012). A question of commitment – improving practitioner responses to domestic and sexual violence, problematic substance use and mental ill-health. *Advances in Dual Diagnosis*, 5(2), 59-67. doi:10.1108/17570971211241912
- Home Office. (2016). *Information guide: adolescent to parent violence and abuse*. London: Home Office. Retrieved from [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/732573/APVA.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/732573/APVA.pdf)
- Home Office. (2016a). *National Statement of Expectations*. London: Home Office. Retrieved from [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/574665/VAWG\\_National\\_Statement\\_of\\_Expectations\\_-\\_FINAL.PDF](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/574665/VAWG_National_Statement_of_Expectations_-_FINAL.PDF)
- Home Office. (2016b). *Violence Against Women and Girls Services: Supporting Local Commissioning*. London: Home Office. Retrieved from [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/576238/VAWG\\_Commissioning\\_Toolkit.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/576238/VAWG_Commissioning_Toolkit.pdf)
- Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal*, 3, 80-100.
- Horvath, A. O., Del Re, A. C., Fluckiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy (Chic)*, 48(1), 9-16. doi:10.1037/a0022186
- Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, 36, 223-233.
- Hughes, I. (2008) 'Action Research in Healthcare', in P. Reason and H. Bradbury (Eds.), *The SAGE Handbook of Action Research: Participative Inquiry and Practice*. London: Sage.
- Hughes, K., Bellis, M. A., Hardcastle, K., Sethi, D., Butchart, A., Mikton, C., . . . M.P., D. (2017). The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *The Lancet*, 2(8), e356-366. doi:10.1016/S2468-2667(17)30118-4



- Humphreys, C., Regan, L., River, D., & Thiara, R. K. (2005). Domestic Violence and Substance Use: Tackling Complexity, *The British Journal of Social Work*, Volume 35, Issue 8 (1), 1303–1320. <https://doi.org/10.1093/bjsw/bch212>
- Humphreys, C., Thiara, R., & Regan, L. (2005). *Domestic Violence and Substance Use: Overlapping Issues in Separate Services? (Briefing report for the Greater London Authority)*. Retrieved from Children and Women's Abuse Studies Unit website: [https://cwasu.org/wp-content/uploads/2016/07/MoL\\_DV\\_SubstanceUse20052.pdf](https://cwasu.org/wp-content/uploads/2016/07/MoL_DV_SubstanceUse20052.pdf)
- Itzin, C., Taket, A., & Barter-Godfrey, S. (2010). *Domestic and sexual violence and abuse: findings from a Delphi expert consultation on therapeutic and treatment interventions with victims, survivors and abusers, children, adolescents, and adults*. Retrieved from Deakin University website: <http://dro.deakin.edu.au/view/DU:30032276>
- Iverson, K. M., Litwack, S. D., Pineles, S. L., Suvak, M. K., Vaughn, R. A., & Resick, P. A. (2013). Predictors of intimate partner violence revictimization: the relative impact of distinct PTSD symptoms, dissociation, and coping strategies. *J Trauma Stress*, 26(1), 102-110. doi:10.1002/jts.21781
- Jonas S., Khalifeh, H., Bebbington P. E., McManus, S., Brugha T, Meltzer, H., and Howard L.M. (2014). Gender differences in intimate partner violence and psychiatric disorders in England: results from the 2007 adult psychiatric morbidity survey. *Epidemiology and Psychiatric Sciences*, 23(2), 189-99. doi:10.1017/S2045796013000292
- Kalathill, J. (2011). *Recovery and resilience: African, African Caribbean and South Asian women's narratives of recovering from mental distress*. Retrieved from <http://www.survivor-research.com/index.php/component/content/article/24-highlights/82-black-women-recovery-and-resilience>
- Kaplan, L.M., Hill, T.D., & Mann-Deibert, G.R. (2012). Does alcohol consumption exacerbate the mental health consequences of interpersonal violence? *Violence Against Women*. 18(3), 289-308.
- Karnieli-Miller, O., Strier, R., & Pessach, L. (2009). Power Relations in Qualitative Research. *Qualitative Health Research*, 19(2), 279-289.
- Kaufman, E.A., Xia, M., Fosco, G. et al. *J Psychopathol Behav Assess* (2016) 38: 443. <https://doi.org/10.1007/s10862-015-9529-3>
- Kelly, A., & Garland, E. L. (2016). Trauma-Informed Mindfulness-Based Stress Reduction for Female Survivors of Interpersonal Violence: Results From a Stage I RCT. *J Clin Psychol*, 72(4), 311-328. doi:10.1002/jclp.22273
- Kendler, K. S., Bulik, C. M., Silberg, J., Hetteman, J. M., Meyers, J., & Prescott, C. (2000). Childhood sexual abuse and adult psychiatric and substance use disorders in women: An epidemiological and co-twin control analysis. *Archives of General Psychiatry*, 57(10), 953-958.
- Khantzian, E. (1997). The self-medication hypothesis of substance use disorders: a reconsideration and recent applications. *Harvard Rev Psychiatry*, 4(5), 231-244



- Killeen, T. K., Back, S. E., & Brady, K. T. (2015). Implementation of integrated therapies for comorbid post-traumatic stress disorder and substance use disorders in community substance abuse treatment programs. *Drug and Alcohol Review*, 34(3), 234-241. doi:10.1111/dar.12229
- Killeen, T.K., Hien, D., Campbell, A., Brown, C., Hansen, C., Jiang, H., . . . Nunes, E. (2008). Adverse events in an integrated trauma-focused intervention for women in community substance abuse treatment. *J Subst Abuse Treat*, 35(3), 304-311. doi:10.1016/j.jsat.2007.12.001
- Kilpatrick, D., Acierno, R., Resnick, H. & Saunders, B. (1997). A 2-year longitudinal analysis of the relationship between violent assault and substance use in women. *Journal of Consulting and Clinical Psychology*, 65, 834–847.
- Kimerling, R., & Calhoun, K. (1999). Traumatic Stress in HIV-infected women. *AIDS Education and Prevention*, 11(4), 321-330.
- King, A. C., & Canada, S. A. (2004). Client-related predictors of early treatment drop-out in a substance abuse clinic exclusively employing individual therapy. *Journal of Substance Abuse Treatment*, 26(3), 189-195. doi:10.1016/s0740-5472(03)00210-1
- Kleim, B., Grey, N., Wild, J., Nussbeck, F. W., Stott, R., Hackmann, A., . . . Ehlers, A. (2013). Cognitive change predicts symptom reduction with cognitive therapy for posttraumatic stress disorder. *J Consult Clin Psychol*, 81(3), 383-393. doi:10.1037/a0031290
- Knudsen, H. K., Ducharme, L. J., Roman, P. M. (2008). Clinical supervision, emotional exhaustion, and turnover intention: A study of substance abuse treatment counselors in the Clinical Trials Network of the National Institute on Drug Abuse. *Journal of Substance Abuse & Treatment*, 35, 387–95.
- Kramer, M., Polusny, M., Arbisi, P., & Krueger, R. (2014). Comorbidity of PTSD and SUDs: Toward an etiologic understanding. In P. Ouimette & J. Read (Eds.), *Trauma and Substance Abuse: Causes, Consequences and Treatment of Comorbid Disorders* (2nd edition.). Washington DC: American Psychological Association.
- Kroenke, K., Spitzer, R., & Williams, J. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16, 606-613.
- Krogel, J., Beecher, M. E., Presnell, J., Burlingame, G., & Simonsen, C. (2009). The group selection questionnaire: a qualitative analysis of potential group members. *International Journal of Group Psychotherapy*, 59(4), 529-542. doi:10.1521/ijgp.2009.59.4.529
- Krueger, R. & Casey, M. (2009) *Focus groups: A practical guide for applied research* (4th Edition). Thousand Oaks, CA: Sage.
- Kubany, E. S., Hill, E. E., Owens, J. A., Iannace-Spencer, C., McCaig, M. A., Tremayne, K. J., & Williams, P. L. (2004). Cognitive Trauma Therapy for Battered Women With PTSD (CTT-BW). *Journal of Consulting and Clinical Psychology*, 72(1), 3-18. doi:10.1037/0022-006X.72.1.3

- La Flair, L. N., Bradshaw, C. P., Storr, C. L., Green, K. M., Alvanzo, A. A. H., & Crum, R. M. (2012). Intimate partner violence and patterns of alcohol abuse and dependence criteria among women. *Journal of Studies on Alcohol and Drugs*, 73(3), 351–360.
- Lakey, B., & Cohen, S. (2000). Social support theory and measurement In S. Cohen & L. Underwood (Eds.), *Social support measurement and intervention: A guide for health and social scientists* (pp. 29-52). New York: Oxford University Press.
- Langford, D. R. (2000). Pearls, Pith and Provocation: developing a safety protocol in qualitative research involving battered women. *Qualitative Health Research*, 10(1), 133-142.
- Laudet, A., Cleland, C., Magura, S., Vogel, H., & Knight, E. (2004). Social Support Mediates the Effects of Dual-Focus Mutual Aid Groups on Abstinence from Substance Use. *American Journal Of Community Psychology*, 34(3/4), 174-184.
- Lee, D. (2012). *The Compassionate Mind Approach to Recovering from Trauma Using Compassion Focused Therapy*. London: Robinson.
- Leon, A. C., Davis, L. L., & Kraemer, H. C. (2011). The role and interpretation of pilot studies in clinical research. *J Psychiatr Res*, 45(5), 626-629. doi:10.1016/j.jpsychires.2010.10.008
- Li, W., Howard, M. O., Garland, E. L., McGovern, P., & Lazar, M. (2017). Mindfulness treatment for substance misuse: A systematic review and meta-analysis. *J Subst Abuse Treat*, 75, 62-96. doi:10.1016/j.jsat.2017.01.008
- Light, M., Grant, E., and Hopkins, K. (2013). *Gender differences in substance misuse and mental health amongst prisoners*. London: Ministry of Justice.
- Lipsky, S., Caetano, R., Field, C. A., & Larkin, G. L. (2005). Psychosocial and substance-use risk factors for intimate partner violence. *Drug and Alcohol Dependence*, 78(1), 39–47. doi:10.1016/j.drugalcdep.2004.08.028
- Litt, M. D., Kadden, R. M., Kabela-Cormier, E., & Petry, N. M. (2009). Changing network support for drinking: network support project 2-year follow-up. *J Consult Clin Psychol*, 77(2), 229-242. doi:10.1037/a0015252
- Levine, P. (2010). *In an Unspoken Voice: How The Body Releases Trauma and Restores Goodness*. Berkeley, CA: North Atlantic Books.
- Lucock, M. P., Hall, P. & Noble, R. (2006). A survey of influences on the practice of psychotherapists and clinical psychologists in training in the UK. *Clinical Psychology and Psychotherapy*, 13, 123–130.
- Luoma, J. B., Kohlenberg, B. S., Hayes, S. C., & Fletcher, L. (2012). Slow and steady wins the race: a randomized clinical trial of acceptance and commitment therapy targeting shame in substance use disorders. *J Consult Clin Psychol*, 80(1), 43-53. doi:10.1037/a0026070
- Macmillan, R. (2010). *The third sector delivering public services: An evidence review*. Third Sector Research Centre, Birmingham, UK.
- Maguire, P., Brydon-Miller, M. & McIntyre, A. (2004). Introduction. In M. Brydon- Miller, P. Maguire & A. McIntyre (Eds.), *Traveling companions: Feminism, teaching, and action research* (pp. 11-18). Westport, CT: Praeger.

- Mahoney, A., Karatzias, T., & Hutton, P. (2019). A systematic review and meta-analysis of group treatments for adults with symptoms associated with complex post-traumatic stress disorder. *J Affect Disord*, 243, 305-321. doi:10.1016/j.jad.2018.09.059
- Manzano, A. (2016). The craft of interviewing in realist evaluation. *Evaluation*, 22(3), 342-360. doi:10.1177/1356389016638615
- Marel, C., Mills, K., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin F.,...Tesson, M. (2016). Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings. Retrieved from the website of Centre of Research Excellence in Mental Health and Substance Use, National Drug and Alcohol Research Centre, University of New South Wales: <https://ndarc.med.unsw.edu.au/resource/guidelines-management-co-occurring-alcohol-and-other-drug-and-mental-health-conditions>.
- Markoff, L. S., Fallot, R. D., Reed, B. G., Elliott, D. E., & Bjelajac, P. (2005). Implementing trauma-informed alcohol and other drug and mental health services for women: Lessons learned in a multisite demonstration project. *American Journal of Orthopsychiatry*, 75(4), 525-539. doi:<http://dx.doi.org/10.1037/0002-9432.75.4.525>
- Marsden, J., Eastwood, B., Wright, C., Bradbury, C., Knight, J., Hammond, P., & National Drug Treatment Monitoring System Outcomes Study, G. (2011). How best to measure change in evaluations of treatment for substance use disorder. *Addiction*, 106(2), 294-302. doi:10.1111/j.
- Marsden, E., & Torgerson, C. J. (2012). Single group, pre- and post-test research designs: Some methodological concerns. *Oxford Review of Education*, 38(5), 583-616. doi:10.1080/03054985.2012.731208
- Marsh, J. C., D'Aunno, T. A., & Smith, B. D. (2000). Increasing access and providing social services to improve drug abuse treatment for women with children. *Addiction*, 95, 1237-1247.
- Marshall, W. L. (2009). Manualization: A blessing or a curse? *Journal of Sexual Aggression*, 15(2), 109-120. doi:10.1080/13552600902907320
- Maxwell, J. (2012). *A Realist Approach for Qualitative Research*. Thousand Oaks, CA: Sage.
- Mayock, P., Cronly, J. & Clatts, M.C. (2015). The Risk Environment of Heroin Use Initiation: Young Women, Intimate Partners, and "Drug Relationships", *Substance Use & Misuse*, 50, 6, 771-782, doi: [10.3109/10826084.2015.978629](https://doi.org/10.3109/10826084.2015.978629)
- McClean, C. P., & Foa, E. B. (2017). Emotions and emotion regulation in posttraumatic stress disorder. *Current Opinion in Psychology*, 14, 72-77.
- McDermott, J. M., Perez-Edgar, K., Henderson, H. A., Chronis-Tuscano, A., Pine, D. S., & Fox, N. A. (2009). A history of childhood behavioral inhibition and enhanced response monitoring in adolescence are linked to clinical anxiety. *Biol Psychiatry*, 65(5), 445-448. doi:10.1016/j.biopsych.2008.10.043
- McDonald, S. D., & Calhoun, P. S. (2010). The diagnostic accuracy of the PTSD checklist: a critical review. *Clin Psychol Rev*, 30(8), 976-987. doi:10.1016/j.cpr.2010.06.012

- McGahan, P. L., Griffith, J. A., Parente, R., & McLellan, A.T. (1986). *Addiction Severity Index Composite Scores Manual*. Philadelphia: The University of Pennsylvania/Veterans Administration Center for Studies of Addiction
- McGovern, M. P., Lambert-Harris, C., Alterman, A. I., Xie, H., & Meier, A. (2011). A Randomized Controlled Trial Comparing Integrated Cognitive Behavioral Therapy Versus Individual Addiction Counseling for Co-occurring Substance Use and Posttraumatic Stress Disorders. *J Dual Diagn*, 7(4), 207-227. doi:10.1080/15504263.2011.620425
- McGovern, M. P., Lambert-Harris, C., Xie, H. Y., Meier, A., McLeman, B., & Saunders, E. B. (2015). A randomized controlled trial of treatments for co-occurring substance use disorders and post-traumatic stress disorder. *Addiction*, 110(7), 1194-1204. doi:<http://dx.doi.org/10.1111/add.12943>
- McHugo, G. J., Caspi, Y., Kammerer, N., Mazelis, R., Jackson, E. W., Russell, L., . . . Kimerling, R. (2005). The assessment of trauma history in women with co-occurring substance abuse and mental disorders and a history of interpersonal violence. *Journal of Behavioral Health Services and Research*, 32(2), 113-127. doi:10.1007/BF02287261
- McHugo, G. J., Kammerer, N., Jackson, E. W., Markoff, L. S., Gatz, M., Larson, M. J., . . . Hennigan, K. (2005). Women, Co-occurring Disorders, and Violence Study: Evaluation design and study population. *Journal of Substance Abuse Treatment*, 28(2), 91-107. doi:<http://dx.doi.org/10.1016/j.jsat.2004.08.009>
- McIntosh, J. & McKeganey, N. (2000). 'The Recovery from Dependent Drug Use: Addicts' Strategies for Reducing the Risk of Relapse', *Drugs: education, prevention, policy*, 7(2), pp179-192
- McIntosh, J. & McKeganey, N. (2009). Identity and Recovery from Dependent Drug Use: the addict's perspective. *Drugs: Education, Prevention and Policy*, 8:1, 47-59, doi: 10.1080/09687630124064
- McKay, J. R. (2005). Is there a case for extended interventions for alcohol and drug use disorders? *Addiction*, 100(11), 1594-1610. doi:10.1111/j.1360-0443.2005.01208.x
- McKay, J. R. (2009). Continuing care research: what we have learned and where we are going. *Journal of Substance Abuse & Treatment*, 36(2), 131-145, doi:10.1016/j.jsat.2008.10.004
- McLellan, A. T., Luborsky, L., Woody, G. E., & O'Brien, C. P. (1980). Improved Diagnostic Evaluation Instrument for Substance Abusers: The Addiction Severity Index. *J Nerv Ment Dis*, 168, 26-33.
- McLellan, A. T., Luborsky, L., Cacciola, J., & Griffith, J. (1985). New data from the Addiction Severity Index: Reliability and validity in three centers. *J Nerv Ment Dis*, 173, 412-423.
- McLellan, A. T., Starrels, J. L., Tai, B., Gordon, A., Brown, R., Ghitza, U., . . . McNeely, J. (2013). Can substance use disorders be managed using the chronic care model? Review and recommendations from a NIDA consensus group. *Public Health Review*, 35(2), 1-12.
- McPherson, M. D., Delva, J. & Cranford, J. A. (2007). A longitudinal investigation of intimate partner violence among mothers with mental illness. *PsychiatrServ*, 58(5), 675–680.

- Meier, A., McGovern, M. P., Lambert-Harris, C., McLeman, B., Franklin, A., Saunders, E. C., & Xie, H. (2015). Adherence and competence in two manual-guided therapies for co-occurring substance use and posttraumatic stress disorders: clinician factors and patient outcomes. *Am J Drug Alcohol Abuse*, 41(6), 527-534. doi:10.3109/00952990.2015.1062894
- Menzies, P. (2012). An Intergenerational Trauma-Informed Approach to Care for Canada's Aboriginal Peoples. In N. Poole & L. Greaves (Eds.), *Becoming Trauma Informed* (pp. 175-187). Toronto, Canada: Centre for Addiction and Mental Health.
- Mertens, J., & Weisner, C. (2000). Predictors of Substance Abuse Treatment Retention Among Women and Men in HMO. *Alcoholism: Clinical and Experimental Research*, 24(10), 1525-1533.
- Messina, N., Calhoun, S., & Warda, U. (2012). Gender Responsive Drug Court Treatment: A Randomized Controlled Trial. *Crim Justice Behav*, 39(12), 1539-1558. doi:10.1177/0093854812453913
- Metropolitan Police Service. (2003). *Findings from Multi-Agency Domestic Violence Murder Reviews in London, UK prepared for the Association of Chief Police Officers Homicide Working Group*. Retrieved from <https://www.dashriskchecklist.co.uk/wp-content/uploads/2016/09/Findings-from-the-Domestic-Homicide-Reviews.pdf>
- Meyer, J. (2000) 'Using qualitative methods in health related action research', *British Medical Journal*, 320: 178–181.
- Michie, S., Atkins, L. & West, R. (2014). *The Behaviour Change Wheel: A Guide to Designing Interventions*. Surrey, UK: Silverback Publishing.
- Michie, S., van Stralen, M. M., & West, R. (2011). The Behaviour Change Wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science*, 6(42). doi: 10.1186/1748-5908-6-42
- Michie, S., Whittington, C., Hamoudi, Z., Zarnani, F., Tober, G., & West, R. (2012). Identification of behaviour change techniques to reduce excessive alcohol consumption. *Addiction*, 107(8), 1431-1440. doi:10.1111/j.1360-0443.2012.03845.x
- Miller, W. R. & Rolnick, S. (2002). *Motivational interviewing: preparing people to change*, 2nd edition. New York: Guildford.
- Miller, W. R., & Wilbourne, P. L. (2002). Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders. *Addiction*, 97(3), 265-277.
- Mills, K. (2015). The importance of providing trauma-informed care in alcohol and other drug services. *Drug & Alcohol Review*. 34, 231-3.
- Mills, K., Back, S. E., Brady, K. T., Baker, A., Teesson, M., Hopwood, S., & Sannibale, C. (2012). *Concurrent treatment of PTSD and substance use disorders using prolonged exposure (COPE), NDARC Technical Report No. 322, Executive Summary*.
- Mills, K. L., Barrett, E. L., Merz, S., Rosenfeld, J., Ewer, P. L., Sannibale, C., . . . Teesson, M. (2016). Integrated Exposure-Based Therapy for Co-Occurring Post Traumatic Stress

- Disorder (PTSD) and Substance Dependence: Predictors of Change in PTSD Symptom Severity. *J Clin Med*, 5(11). doi:10.3390/jcm5110101
- Mills, K. L., Marel, C., Darke, S., Ross, J., Slade, T., & Teesson, M. (2018). The long-term impact of post traumatic stress disorder on recovery from heroin dependence. *Journal of Substance Abuse Treatment*, 89, 60-66. doi:10.1016/j.jsat.2018.04.001
- Mills, K.L., Teesson, M., Back, S. E., Brady, K., Baker, A., Hopwood, S., . . . Ewer, P. (2012). Integrated Exposure-Based Therapy for Co-occurring Posttraumatic Stress Disorder and Substance Dependence A Randomized Controlled Trial. *Journal of the American Medical Association*, 308(7), 690-699.
- Milward, J., Lynskey, M., & Strang, J. (2014). Solving the problem of non-attendance in substance abuse services. *Drug Alcohol Rev*, 33(6), 625-636. doi:10.1111/dar.12194
- Ministry of Justice. (2018). *Female Offender Strategy*. Retrieved from [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/719819/female-offender-strategy.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/719819/female-offender-strategy.pdf)
- Mockus, S., Mars, L. C., Ovard, D. G., Mazelis, R., Bjelajac, P., Grady, J., . . . McKinney, J. (2005). Developing Consumer/Survivor/Recovering Voice and Its Impact on Services and Research: Our Experience With the SAMHSA Women, Co-Occurring Disorders and Violence Study. *Journal of Community Psychology*, 33(4), 513-525. doi:<http://dx.doi.org/10.1002/jcop.20066>
- Moher, D., Hopewell, S., Schulz, K. F., Montori, V., Gøtzsche, P. C., Devereaux, P. J., . . . Altman, D. G. (2010). *CONSORT 2010 Explanation and Elaboration: updated guidelines for reporting parallel group randomised trials* (Vol. 340). *BMJ* 2010;340:c332
- Moore, G., Audrey, S., Barker, M., Bond, L., Bonell, C., Hardeman, W., . . . Baird, J. (2015). Process evaluation of complex interventions: Medical Research Council guidance. *British Medical Journal*, 350(h1258)
- Moos, R. H. (2007). Theory-Based Active Ingredients of Effective Treatments for Substance Use Disorders. *Drug and Alcohol Dependence*, 88(2-3), 109-121.
- Morgan, D. (2007). Paradigms Lost and Pragmatism Regained: Methodological Implications of Combining Qualitative and Quantitative Methods. *Journal of Mixed Methods Research*, 1(1), 48-76.
- Morgan-Lopez A.A, Saavedra L.M, Hien D.A, Campbell A.N, Wu E, & Ruglass L. (2013). Synergy between Seeking Safety and Twelve-Step Affiliation on substance use outcomes for women. *Journal of Substance Abuse Treatment*, 45(2), 179-189.
- Morgan-Lopez, A. A., Saavedra, L. M., Hien, D. A., Campbell, A. N., Wu, E., Ruglass, L., . . . Bainter, S. C. (2014). Indirect effects of 12-session Seeking Safety on substance use outcomes: Overall and attendance class-specific effects. *American Journal of Addictions*, 23(3), 218-225.
- Morrissey, J. P., Ellis, A. R., Gatz, M., Amaro, H., Reed, B. G., Savage, A., . . . Banks, S. (2005). Outcomes for women with co-occurring disorders and trauma: Program and person-level

- effects. *Journal of Substance Abuse Treatment*, 28(2), 121-133.  
doi:<http://dx.doi.org/10.1016/j.jsat.2004.08.012>
- Morrissey, J. P., Jackson, E. W., Ellis, A. R., Amaro, H., Brown, V. B., & Najavits, L. M. (2005). Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatric services (Washington, D.C.)*, 56(10), 1213-1222.  
doi:10.1176/appi.ps.56.10.1213
- Moses, D. J., & Ambrosio, B. D. (2004). *Developing Integrated Services for Women with Co-Occurring Disorders and Trauma Histories Lessons from the SAMHSA Women Drug Abuse and Mental Health Disorders who have Histories of Violence Study*. Delmar, NY: Policy Research Associates.
- Moses, D. J., Reed, B. G., Mazelis, R., & D'Ambrosio, D. (2003). *Creating Trauma Services for Women with Co-Occurring Disorders: Experiences from the SAMHSA Women with Alcohol, Drug Abuse and Mental Health Disorders who have Histories of Violence Study*. Delmar, NY: Policy Research Associates.
- Mueser, K. T., Gottlieb, J. D., Xie, H., Lu, W., Yanos, P. T., Rosenberg, S. D., . . . McHugo, G. J. (2015). Evaluation of cognitive restructuring for post-traumatic stress disorder in people with severe mental illness. *Br J Psychiatry*, 206(6), 501-508.  
doi:10.1192/bjp.bp.114.147926
- Mueser, K.T., Rosenberg, S.D. & Rosenberg, H. J. (2009). *Treatment of posttraumatic stress disorder in special populations: a cognitive restructuring program*. Washington, DC: American Psychological Association.
- Munder, T., Wilmers, F., Leonhart, R., Linster, H. W., & Barth, J. (2010). Working Alliance Inventory-Short Revised (WAI-SR): psychometric properties in outpatients and inpatients. *Clin Psychol Psychother*, 17(3), 231-239. doi:10.1002/cpp.658
- Myers, U. S., Browne, K. C., & Norman, S. B. (2015). Treatment Engagement: Female Survivors of Intimate Partner Violence in Treatment for PTSD and Alcohol Use Disorder. *J Dual Diagn*, 11(3-4), 238-247. doi:10.1080/15504263.2015.1113762
- Myhill, A. (2015). Measuring coercive control: what can we learn from national population surveys? *Violence Against Women*, 21(3), 355-375. doi:10.1177/1077801214568032
- Najavits, L. M. (1994). Variations in therapist effectiveness in the treatment of patients with substance use disorders: an empirical review. *Addiction*, 89(6), 679-688.
- Najavits, L. M. (1995). *Core Components of Treatment Questionnaire.*, Boston, MA: Harvard Medical School/McLean Hospital.
- Najavits, L. M. (2002). *Seeking Safety. A Treatment Manual for PTSD and Substance Abuse*. New York: Guildford Press.
- Najavits, L. M. (2003). *Seeking Safety Adherence Scale*. Retrieved from Treatment Innovations website: <https://www.treatment-innovations.org/assessment.html>
- Najavits, L. M. (2004). Treatment of Posttraumatic Stress Disorder and Substance Abuse: Clinical Guidelines for Implementing Seeking Safety Therapy. *Alcoholism Treatment Quarterly*, 22(1), 43-62.



- Najavits, L. M. (2009). Seeking Safety: An Implementation Guide. In A. Rubin & D. Springer (Eds.), *The Clinician's Guide to Evidenced Based Practice* (pp. 311-347). Hoboken, NJ: John Wiley.
- Najavits, L. M., & Hien, D. A. (2013). Helping vulnerable populations: a comprehensive review of the treatment outcome literature on substance use disorder and PTSD. *Journal of clinical psychology*, 69(5), 433-479. doi:10.1002/jclp.21980
- Najavits, L. N., Kivlahan, D. R., & Kosten, T. (2011). A national survey of clinicians' views of evidence-based therapies for PTSD and substance abuse. *Addiction Research and Theory*, 19(2), 138-147. doi:10.3109/16066350903560176
- Najavits, L., Weiss, R. D., & Shaw, S., R. (1997). The Link Between Substance Abuse and Post-traumatic Stress Disorder in Women. *The American Journal on Addictions*, 6(4), 273-283.
- Natcen Social Research. (2013). *Violence, Abuse and Mental Health in England; Preliminary Evidence Briefing, Latent Class Analysis of the Adult Psychiatric Morbidity Survey*. Retrieved from Natcen website: <http://www.natcen.ac.uk/media/1058443/REVA-Strand-1-technical-report.pdf>
- National Health Service (NHS), National Treatment Agency for Substance Misuse. (2005). *Retaining Clients in Drug Treatment, a guide for providers and commissioners*. London: NHS. Retrieved from [http://www.emcdda.europa.eu/attachements.cfm/att\\_231381\\_EN\\_UK25\\_guidance\\_reten tion.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_231381_EN_UK25_guidance_reten tion.pdf)
- National Institute for Health and Care Excellence. (2014). *Domestic Violence and Abuse: multi-agency working (Public Health Guidance PH50)*. Retrieved from <https://www.nice.org.uk/Guidance/PH50>
- National Institute for Health and Care Excellence. (2015). *Surveillance Review Decsion of CG26 Post-traumatic stress disorder: The management of PTSD in adults and children in primary and secondary care*. NICE Centre for Clinical Practice – Surveillance Programme. Retrived from <https://www.nice.org.uk/guidance/cg26/evidence>
- National Institute for Health and Care Excellence. (2016). *Coexisting severe mental illness and substance misuse: community health and social care services* (NICE Guideline NG58). Retrieved from <https://www.nice.org.uk/guidance/ng58>
- National Institute for Health and Care Excellence. (2018). *Post-traumatic Stress Disorder* (NICE Guideline NG116). Retrieved from <https://www.nice.org.uk/guidance/ng116/resources/posttraumatic-stress-disorder-pdf-66141601777861>
- National Institute for Health Research (NIHR) and INVOLVE. (2018). *Guidance on Co-producing a research project*. Retrieved from [https://www.invo.org.uk/wp-content/uploads/2018/03/Copro\\_Guidance\\_Mar18.pdf](https://www.invo.org.uk/wp-content/uploads/2018/03/Copro_Guidance_Mar18.pdf)
- Neale, J., Nettleton, S. & Pickering, L. (2014). Gender sameness and difference in recovery from heroin dependence: a qualitative exploration. *International Journal of Drug Policy* 25, 3–12.



- Neale, J., Tompkins, C. N. E., Marshall, A. D., Treloar, C., & Strang, J. (2018). Do women with complex alcohol and other drug use histories want women-only residential treatment? *Addiction*, 113(6), 989-997. doi:10.1111/add.14131
- Nelson-Zlupko L., Kauffman E., Dore M. M (1995). Gender differences in drug addiction and treatment: implications for social work intervention with substance-abusing women. *Journal of Social Work* 40, 45–54.
- Nishith, P., Nixon, R. D. V., & Resick, P. A. (2005). Resolution of trauma-related guilt following treatment of PTSD in female rape victims: A result of cognitive processing therapy targeting comorbid depression? *Journal of Affective Disorders*, 86(2-3), 259-265. doi:10.1016/j.jad.2005.02.013
- Niv N., Hser Y. I. (2007). Women-only and mixed-gender drug abuse treatment programs: service needs, utilization and outcomes. *Drug & Alcohol Dependence*, 87, 194–201.
- Norman, S. (no date). Alcohol Use Disorders and post-traumatic stress disorder treatment for victims of partner violence. <https://clinicaltrials.gov/ct2/show/study/NCT00607412>
- NVivo Qualitative Data Analysis Software (Versions 10 & 12). [Computer Software]. QSR International Pty Ltd. Melbourne, Australia.
- Oakley, A. (1980). *Women Confined: Towards a Sociology of Childbirth*. Oxford: Martin Robertson.
- Oakley, A. (1981). Interviewing women: A contradiction in terms? In: Roberts H (ed.), *Doing Feminist Research* (pp 30-61). London: Routledge and Kegan Paul.
- O'Campo, P., Kub, J., Woods, A., Garza, M., Snow Jones, A., Gielen, A., . . . Campbell, J. (2006). Depression, PTSD, and Comorbidity Related to Intimate Partner Violence in Civilian and Military Women. *Brief Treatment and Crisis Intervention*, 6(2), 99-110.
- O'Cathain, A., Hoddinott, P., Lewin, S., Thomas, K. J., Young, B., Adamson, J., . . . Donovan, J. L. (2015). Maximising the impact of qualitative research in feasibility studies for randomised controlled trials: guidance for researchers. *Pilot Feasibility Stud*, 1, 32. doi:10.1186/s40814-015-0026-y
- Ogden, P., & Minton, K. (2000). Sensorimotor Psychotherapy: One Method for Processing Traumatic Memory. *Traumatology*, 3(3), 149-173.
- Olatunji, B. O., Ciesielski, B. G. & Tolin, D. F. (2010). Fear and loathing: A meta-analytic review of the specificity of anger-in PTSD. *Behavior Therapy*. 41, 93–105.
- Olav Melberg, H. (2009). Three problems with the ASI composite scores. *Journal of Substance Use*, 9(3-4), 120-126. doi:10.1080/14659890410001720887
- Orford, J. (2008). Asking the right questions in the right way: the need for a shift in research on psychological treatments for addiction. *Addiction*, 103(6), 875-885; discussion 886-892. doi:10.1111/j.1360-0443.2007.02092.x
- Ouimette, P. C., Coolhart, D., Funderburk, J. S., Wade, M., & Brown, P. J. (2007). Precipitants of first substance use in recently abstinent substance use disorder patients with PTSD. *Addictive Behaviors*, 32, 1719-1727.

- Panchanadeswaran, S., El-Bassel, N., Gilbert, L., Wu, E., & Chang, M. (2008). An examination of the perceived social support levels of women in methadone maintenance treatment programs who experience various forms of intimate partner violence. *Women's Health Issues, 18*(1), 35-43. doi:10.1016/j.whi.2007.10.007
- Patel, M., Doku, V., & Tennakoon, L. (2003). Challenges in recruitment of research participants. *Advances in Psychiatric Treatment, 9*(3), 229-238.
- Patton, M.Q. 1990: Qualitative evaluation and research methods (2nd edition). Beverly Hills, CA: Sage.
- Pawson, R., Boaz, A., Grayson, L., Long, A., & Barnes, C. (2003). *Types and Quality of Knowledge in Social Care*. Retrieved from SCIE website <https://www.scie.org.uk/publications/knowledgereviews/kr03.pdf>
- Pawson, R., & Tilley, N. (1997). *Realistic Evaluation*. London: Sage.
- Pelcovitz, D., van der Kolk, B., Roth, S., Mandel, F., Kaplan, S., & Resick, P. A. (1997). Development of a criteria set and a structured interview for disorders of extreme stress (SIDES). *Journal of Traumatic Stress, 10*, 3–16. doi:10.1002/jts.2490100103
- Perez-Dandieu, B., & Tapia, G. (2014). Treating Trauma in Addiction with EMDR: A Pilot Study. *J Psychoactive Drugs, 46*(4), 303-309. doi:10.1080/02791072.2014.921744
- Persson, A., Back, S. E., Killeen, T. K., Brady, K. T., Schwandt, M. L., Heilig, M., & Magnusson, A. (2017). Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE): A Pilot Study in Alcohol-dependent Women. *J Addict Med, 11*(2), 119-125. doi:10.1097/ADM.0000000000000286
- Petticrew, M., Anderson, L., Elder, R., Grimshaw, J., Hopkins, D., Hahn, R., . . . Welch, V. (2015). Complex interventions and their implications for systematic reviews: A pragmatic approach. *Int J Nurs Stud, 52*(7), 1211-1216. doi:10.1016/j.ijnurstu.2015.01.004.
- Phoenix, A. (1994). Practising feminist research: the intersections of gender and 'race' in the research process. In Maynard M and Purvis J (Eds.) *Researching Women's Lives from a Feminist Perspective*. London: Taylor and Francis.
- Pillow, W. (2003). Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *International Journal of Qualitative Studies in Education, 16*(2), 175-196. doi:10.1080/0951839032000060635
- Pinheiro, P. S. (2006). *Report of the independent expert for the United Nations Secretary General's study on violence against children*: Retrieved from the website of the United Nations Children's Fund: <https://www.unicef.org/violencestudy/I.%20World%20Report%20on%20Violence%20against%20Children.pdf>
- Pinto, R. M., Campbell, A. N., Hien, D. A., Yu, G., & Gorroochurn, P. (2011). Retention in the National Institute on Drug Abuse Clinical Trials Network Women and Trauma Study: implications for posttrial implementation. *Am J Orthopsychiatry, 81*(2), 211-217. doi:10.1111/j.1939-0025.2011.01090.

- Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., . . . Duffy, S. (2006). *Guidance on the Conduct of Narrative Synthesis in Systematic Reviews; A Product from the ESRC Methods Programme*. Retrieved from <http://www.lancaster.ac.uk/shm/research/nssr/research/dissemination/publications.php>
- Prendergast, M. L., Messina, N. P., Hall, E. A., & Warda, U. S. (2011) The relative effectiveness of women-only and mixed-gender treatment for substance-abusing women. *J Subst Abuse Treatment*. 40, 336–348.
- Prestidge, J. (2014). Using Trauma-Informed Care to provide therapeutic support to homeless people with complex needs: a transatlantic search for an approach to engage the “non-engaging”. *Housing, Care and Support*, 17(4), 208-214. doi:10.1108/hcs-09-2014-0024
- Prison Reform Trust. (2014). *Brighter Futures, Working Together to Reduce Women’s Offending*. Retrieved from <http://www.prisonreformtrust.org.uk/Portals/0/Documents/Brighter%20Futures%2025314web.pdf>
- Price, C. J., Wells, E. A., Donovan, D. M., & Rue, T. (2012). Mindful awareness in body-oriented therapy as an adjunct to women's substance use disorder treatment: a pilot feasibility study. *J Subst Abuse Treat*, 43(1), 94-107. doi:10.1016/j.jsat.2011.09.016
- Price, C. J., Wells, E. A., Donovan, D. M., & Brooks, M. (2012a). Implementation and acceptability of Mindful Awareness in Body-oriented Therapy in women's substance use disorder treatment. *J Altern Complement Med*, 18(5), 454-462. doi:10.1089/acm.2011.0126
- Price, C., & Smith-DiJulio, K. (2016). Interoceptive Awareness Is Important for Relapse Prevention: Perceptions of Women Who Received Mindful Body Awareness in Substance Use Disorder Treatment. *Journal of addictions nursing*, 27(1), 32-38.
- Public Health England. (2018). *Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2017 to 31 March 2018*. Retrieved from [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/752993/AdultSubstanceMisuseStatisticsfromNDTMS2017-18.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/752993/AdultSubstanceMisuseStatisticsfromNDTMS2017-18.pdf)
- Radford, L., Corral, S., Bradley, C., Fisher, H., Howat, N., Bassett, C., & Collishaw, S. (2010). *The prevalence of child maltreatment and victimisation in the UK*. Retrieved from the NSPCC website: <https://learning.nspcc.org.uk/media/1042/child-abuse-neglect-uk-today-research-report.pdf>
- Recovery Partnership & Adfam. (2017). *State of the Sector 2015*. London: Recovery Partnership, Adfam.
- Reddy, S., Dick, A. M., Gerber, M. R., & Mitchell, K. (2014). The effect of a yoga intervention on alcohol and drug abuse risk in veteran and civilian women with posttraumatic stress disorder. *Journal of Alternative and Complementary Medicine*, 20(10), 750-756. doi:http://dx.doi.org/10.1089/acm.2014.0014
- Reed, P. L., Anthony, J. C., & Breslau, N. (2007). Incidence of drugs problems in young adults exposed to trauma and post-traumatic stress disorder: Do early life experiences and predispositions matter? *Archives of General Psychiatry*, 64, 1435-1422.

- Rees, S., Silove, D., Chey, T., Ivancie, L., Steel, Z., Creamer, M., . . . Forbes, D. (2011). Lifetime Prevalence of Gender Based Violence in Women and the Relationship with Mental Disorders and Psychosocial Function. *Journal of the American Medical Association*, 306(5), 513-521.
- Reid, C., Tom, A., & Frisby, W. (2006). Finding the 'action' in feminist participatory action research. *Action research*, 4(3), 315-332. doi:10.1177/1476750306066804
- Resick, P. A., Miller, M. W. (2009). Posttraumatic stress disorder: anxiety or traumatic stress disorder? *Journal of Traumatic Stress*, 22 (384), 384-390.
- Resick, P. A., Nishith, P., Weaver, T. L., Astin, M. C., & Feuer, C. A. (2002). A comparison of Cognitive-Processing Therapy with Prolonged Exposure and a Waiting Condition for the Treatment of Chronic Posttraumatic Stress Disorder in Female Rape Victims. *Journal of Consulting and Clinical Psychology*, 70(4), 867-879. doi:10.1037/0022-006X.70.4.867
- Resko, S. M., & Mendoza, N. S. (2012). Early attrition from treatment among women with cooccurring substance use disorders and PTSD. *Journal of Social Work Practice in the Addictions*, 12(4), 348-369.
- Resnick, H., S., Kilpatrick, D., G., Dansky, B. S., Saunders, B. E., Best, C. L. (1993). Prevalence of civilian trauma and posttraumatic stress disorder in a representative national sample of women. *Journal of Consulting and Clinical Psychology*, 61(6), 984-991.
- Reynolds, M., Mezey, G., Chapman, M., Wheeler, M., Drummond, C., & Baldacchino, A. (2005). Co-morbid post-traumatic stress disorder in a substance misusing clinical population. *Drug Alcohol Depend*, 77(3), 251-258. doi:10.1016/j.drugalcdep.2004.08.017
- Rhodes, T., & Coomber, R. (2010). *Qualitative methods and theory in addictions research*. Oxford: Wiley-Blackwell.
- Richardson, L. (2000). Evaluating ethnography. *Qualitative Inquiry*, 6, 253-256.
- Ritchie, J., Lewis, J., McNaughton Nicholls, C., & Ormston, R. (2014). *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. London: SAGE.
- Roberts, N. P., Roberts, P. A., Jones, N., & Bisson, J. I. (2016). Psychological therapies for post-traumatic stress disorder and comorbid substance use disorder. *Cochrane Database of Systematic Reviews*(4). doi:10.1002/14651858.CD010204.pub2.
- Rogers, E. M. (1995). *Diffusion of Innovations*. 4<sup>th</sup> ed, New York, The Free Press.
- Rosenberg, M. (1965). *Society and the adolescent self-image*. Princetown, NJ: Princeton University Press.
- Roth, S., Newman, E., Pelcovitz, D., Van der Kolk, B., & Mandel, F. S. (1997). Complex PTSD in Victims Exposed to Sexual and Physical Abuse: results from the DSM-IV Field Trial for Post Traumatic Stress Disorder. *Journal of Traumatic Stress*, 10(4).
- Roth, T., & Pilling, S. (2007). The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders. Improving access to psychological therapies (IAPT) programme. Retrieved from <http://www.ucl.ac.uk/clinical-psychology/>

- Rothschild, B. (2011). *Trauma Essentials: The Go To Guide* (1<sup>st</sup> edition). New York: W.W. Norton & Company Inc.
- Ruglass, L.M, Miele, G.M, Hien, D.A, Campbell, A.N, Hu, M.C, Caldeira, N., . . . Nunes, E.V. (2012). Helping alliance, retention, and treatment outcomes: a secondary analysis from the NIDA Clinical Trials Network Women and Trauma Study. *Substance use and misuse*, 47(6), 695-707.
- Ruglass, L. M., Hien, D. A., Hu, M.-C., & Campbell, A. N. C. (2014). Associations between post-traumatic stress symptoms, stimulant use, and treatment outcomes: A secondary analysis of NIDA's Women and Trauma Study. *Am J Addict*. 23(1), doi:10.1111/j.1521-0391.2013.12068.x.
- Sacks, S., McKendrick, K., Sacks, J. Y., Banks, S., & Harle, M. (2008). Enhanced outpatient treatment for co-occurring disorders: main outcomes. *J Subst Abuse Treat*, 34(1), 48-60. doi:10.1016/j.jsat.2007.01.009
- Sackett, L. A., & Saunders, D. G. (1999). The impact of different forms of psychological abuse on battered women. *Violence & Victims*, 14, 105-117.
- Sannibale, C., Teesson, M., Creamer, M., Sitharthan, T., Bryant, R. A., Sutherland, K., . . . Peek-O'Leary, M. (2013). Randomized controlled trial of cognitive behaviour therapy for comorbid post-traumatic stress disorder and alcohol use disorders. *Addiction*, 108(8), 1397-1410. doi:10.1111/add.12167
- Savage, C. L., Wray, J. N., Ritchey, P. N., & Fulmer, M. (2002). Measurement of maternal alcohol consumption in a pregnant population. *Substance Abuse*, 23(4), 211-214.
- Saunders, E. C., McLeman, B. M., McGovern, M. P., Xie, H., Lambert-Harris, C., & Meier, A. (2016). The influence of family and social problems on treatment outcomes of persons with co-occurring substance use disorders and PTSD. *Journal of Substance Use*, 21(3), 237-243.
- Saunders, J. B., Aasland, O. G., Babor, T. F., Fuente, J. R. d. I., & Grant, M. (1993). Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption - II. *Addiction*, 88, 791-804.
- Savage, A., & Russell, L. A. (2005). Tangled in a web of affiliation: Social support networks of dually diagnosed women who are trauma survivors. *Journal of Behavioral Health Services and Research*, 32(2), 199-214. doi:<http://dx.doi.org/10.1007/BF02287267>
- Scerri, C. S., Abela, A., & Vetere, A. (2012). Ethical dilemmas of a clinician/researcher interviewing women who have grown up in a family where there was domestic violence. *International journal of qualitative methods*, 11(2), 102-131.
- Schafer, I., Gromus, L., Atabaki, A., Pawils, S., Verthein, U., Reimer, J., . . . Martens, M. (2014). Are experiences of sexual violence related to special needs in patients with substance use disorders? A study in opioid-dependent patients. *Addict Behav*, 39(12), 1691-1694. doi:10.1016/j.addbeh.2014.07.008
- Scottish Government. (2012). *Mental Health Strategy for Scotland: 2012-2015*. Retrieved from <http://www.gov.scot/Publications/2012/08/9714>

- Shapiro, F. (2001). *Eye Movement Desensitization and Reprocessing (EMDR): basic principles, protocols, and procedures* (2nd edition). New York: Guildford Press.
- Shields, A. L., & Caruso, J. C. (2003). Reliability generalization of the Alcohol Use Disorders Identification Test. *Educational and Psychological Measurement*, 63(3), 404-413
- Siegel, D. (1999). *The Developing Mind*. New York: Guildford Press.
- Simpson, D. D. (2002). A conceptual framework for transferring research to practice. *Journal of Substance Abuse Treatment*, 22, 171-182
- Simpson, M., & McNulty J. (2008). Different needs: women's drug use and treatment in the UK. *International Journal of Drug Policy*, 19: 169–175.
- Simpson, T., Stappenbeck, C., Varra, A., Moore, S., & Kaysen, D. (2012). Symptoms of posttraumatic stress predict craving among alcohol treatment seekers: Results of a daily monitoring study. *Psychology of Addictive Behaviours*, 26(724-733).
- Sklar, S. M., Annis, H., Turner, N. E. (1997). Development and validation of the Drug-Taking Confidence Questionnaire: A measure of coping self-efficacy. *Addictive Behaviors* 22:655–670.
- Sloan, E., Hall, K., Moulding, R., Bryce, S., Mildred, H., & Staiger, P. K. (2017). Emotion regulation as a transdiagnostic treatment construct across anxiety, depression, substance, eating and borderline personality disorders: A systematic review. *Clin Psychol Rev*, 57, 141-163. doi:10.1016/j.cpr.2017.09.002
- Smyth, K. F., Goodman, L., & Glenn, C. (2006). The full-frame approach: a new response to marginalized women left behind by specialized services. *American Journal of Orthopsychiatry* 76(4), 489-502.
- Spitzer, R., Kroenke, K., Williams, J., & the Patient Health Questionnaire Primary Care Study Group. (1999). Validation and utility of a self-report version of PRIME-MD: the PHQ Primary Care Study. *Journal of the American Medical Association*, 282, 1737-1744.
- StataCorp. 2013. *Stata Statistical Software: Release 13*. College Station, TX: StataCorp LP.
- Stevens, E., Jason, L. A., Ram, D., & Light, J. (2015). Investigating Social Support and Network Relationships in Substance Use Disorder Recovery. *Subst Abus*, 36(4), 396-399. doi:10.1080/08897077.2014.965870
- Stewart, S., & Conrod, P. (2003). Psychosocial models of functional associations between posttraumatic stress disorder and substance use disorder. In P. Ouimette & P. Brown (Eds.), *Trauma and Substance Abuse: Causes, Consequences and Treatment of Comorbid Disorders* (pp. 29-55). Washington, D.C.: American Psychological Association.
- Stiles, W. B., Agnew-Davies, R., Hardy, G., Barkham, D., & Shapiro, D. (1998). Relations of the alliance with psychotherapy outcome: Findings in the second Sheffield psychotherapy project. *Journal of Consulting and Clinical Psychology*, 66, 791-802.
- Sobell, L. C., & Sobell, M. B. (1995). *Alcohol timeline followback users' manual*. Toronto: Addiction Research Foundation.



- Sobell, L. C., & Sobell, M. B. (2000). Alcohol Timeline Followback (TLFB). In American Psychiatric Association (Ed.), *Handbook of psychiatric measures* (pp. 477-479). Washington, DC: American Psychiatric Association.
- Sterne, J., White, I., Carlin, J., Spratt, M., Royston, P., Kenward, M., Wood, A., & Carpenter, J. (2009). Multiple imputation for missing data in epidemiological and clinical research: potential and pitfalls. *British Medical Journal* 338, doi: b2393-10.1136/bmj.b2393.
- Stewart, S., & Conrod, P. (2003). Psychosocial models of functional associations between posttraumatic stress disorder and substance use disorder. In P. Ouimette & P. Brown (Eds.), *Trauma and Substance Abuse: Causes, Consequences and Treatment of Comorbid Disorders* (pp. 29-55). Washington, D.C.: American Psychological Association.
- Stirman, S. W., Kimberly, J., Cook, N., Calloway, A., Castro, F. & Charns, M. (2012). The sustainability of new programs and interventions: A review of the empirical literature and recommendations for future research. *Implementation Science*, 7:17.
- Stirman, S. W., Miller, C. J., Toder, K., & Calloway, A. (2013). Development of a framework and coding system for modifications and adaptations of evidence-based interventions. *Implement Sci*, 8, 65. doi:10.1186/1748-5908-8-65
- Stroud, D. D. (1999). Familial support as perceived by adult victims of childhood sexual abuse. *Sex Abuse*, 11 (2), 159–175.
- Sullivan, T. P., & Holt, L. J. (2008). PTSD symptom clusters are differentially related to substance use among community women exposed to intimate partner violence. *J Trauma Stress*, 21(2), 173-180. doi:10.1002/jts.20318
- Sullivan, T. P., Weiss, N. H., Flanagan, J. C., Willie, T. C., Armeli, S., & Tennen, H. (2016). PTSD and Daily Co-Occurrence of Drug and Alcohol Use Among Women Experiencing Intimate Partner Violence. *J Dual Diagn*, 12(1), 36-42. doi:10.1080/15504263.2016.1146516
- Swan, S., & Farber, S. *Violence in the Lives of Women in Substance Abuse Treatment: Service and Policy Implications*. Retrieved from <http://citeseerx.ist.psu.edu/viewdoc/download;jsessionid=403A9F402E61DA65456FBE710BE7384?doi=10.1.1.216.2952&rep=rep1&type=pdf>
- Swan, S., & Snow, D. (2002). A typology of women's use of violence in intimate relationships. *Journal of Violence Against Women*, 8(3), 286–319.
- Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: what is it and how can we further its development? *Mental Health Review Journal*, 21(3), 174-192. doi:10.1108/mhrj-01-2015-0006
- Swendsen, J., Conway, K. P., Degenhardt, L., Glantz, M., Jin, R., Merikangas, K. R., . . . Kessler, R. C. (2010). Mental disorders as risk factors for substance use, abuse and dependence. Results from a 10 year follow up of the National Co-morbidity Survey. *Addiction*, 105, 1117-1128.
- Swopes, R. M., Davis, J. L., & Scholl, J. A. (2015). Treating Substance Abuse and Trauma Symptoms in Incarcerated Women: An Effectiveness Study. *J Interpers Violence*, 32(7), 1143–1165. doi: 10.1177/0886260515587668

- Tang, N. (2002). Interviewer and Interviewee Relationships Between Women. *Sociology*, 36(3), 703–721. <https://doi.org/10.1177/0038038502036003011>
- Tashakkori, A., & Teddlie, C. (2010). *Handbook of Mixed Methods in social and behavioural research* (2nd edition). Thousand Oaks: CA: Sage.
- Teets, J. M. (1999). The incidence and experience of rape among chemically dependent women. *Journal of Psychoactive Drugs*. 29(4), 331-6.
- Thomson, C. L., Morley, K. C., Teeson, M., Sannibale, C., & Haber P. S. (2008). Issues with recruitment to randomised controlled trials in the drug and alcohol field: a literature review and Australian case study. *Drug & Alcohol Review* 27: 115–122.
- Tirado-Munoz, J., Gilchrist, G., Fischer, G., Taylor, A., Moskalewicz, J., Giammarchi, C., . . . Torrens, M. (2018). Psychiatric comorbidity and intimate partner violence among women who inject drugs in Europe: a cross-sectional study. *Arch Womens Ment Health*, 21(3), 259-269. doi:10.1007/s00737-017-0800-3
- Tivis, L. J., Parsons, O. A., & Nixon, S. J. (1998). Anger in an Inpatient Treatment Sample of Chronic Alcoholics. *Alcoholism Clinical and Experimental Research*, 22(4), 902-907 <https://doi.org/10.1111/j.1530-0277.1998.tb03887.x>
- Tompkins, C. N. E., & Neale, J. (2016). Delivering trauma-informed treatment in a women-only residential rehabilitation service: Qualitative study. *Drugs: Education, Prevention and Policy*, 1-9. doi:10.1080/09687637.2016.1235135
- Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Healthcare*. 19(6), 349-57.
- Torchalla, I., Nosen, L., Rostam, H., & Allen, P. (2012). Integrated treatment programs for individuals with concurrent substance use disorders and trauma experiences: A systematic review and meta-analysis. *Journal of Substance Abuse Treatment*, 42(1), 65-77. doi:10.1016/j.jsat.2011.09.001
- Toussaint, D. W., VanDeMark, N. R., Bornemann, A., & Graeber, C. J. (2007). Modifications to the Trauma Recovery and Empowerment Model (TREM) for substance-abusing women with histories of violence: Outcomes and lessons learned at a Colorado substance abuse treatment center. *Journal of Community Psychology*, 35(7), 879-894. doi:10.1002/jcop.20187
- Tracy, S. J. (2010). Qualitative Quality: Eight “Big-Tent” Criteria for Excellent Qualitative Research. *Qualitative Inquiry*, 16(10), 837-851. doi:10.1177/1077800410383121
- Trevillion, K., Oram, S., Feder, G., & Howard, L. M. (2012). Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis. *PLoS ONE*, 7(12). doi:10.1371/journal.pone.0051740
- Triffleman, E. (2000). Gender Differences in a Controlled Pilot Study of Psychosocial Treatments in Substance Dependent Patients with Post-Traumatic Stress Disorder. *Alcoholism Treatment Quarterly*, 18(3), 113-126. doi:10.1300/J020v18n03\_10



- Triffleman, E., Carroll, K., & Kellogg, S. (1999). Substance Dependence Posttraumatic Stress Disorder Therapy, An Integrated Cognitive-Behavioral Approach. *Journal of Substance Abuse Treatment*, 17 (1-2), 3-4.
- Trucco, E.M., Connery, H.S., Griffin, M.L., & Greenfield, S.F. (2007). The relationship of self-esteem and self-efficacy to treatment outcomes of alcohol-dependent men and women. *The American Journal on Addictions* 16:85–92.
- Tucker, J. S., D'Amico, E. J., Wenzel, S. L., Golinelli, D., Elliot, M. N., & Williamson, S. (2005). A prospective study of risk and protective factors for substance use among impoverished women living in temporary shelter settings in Los Angeles County. *Journal of Drug and Alcohol Dependence*, 80, 35–43.
- Tull, M. T., Bardeen, J. R., DiLillo, D., Messman-Moore, T., & Gratz, K. L. (2015). A prospective investigation of emotion dysregulation as a moderator of the relation between posttraumatic stress symptoms and substance use severity. *J Anxiety Disord*, 29, 52-60. doi:10.1016/j.janxdis.2014.11.003
- US Department of Health and Human Services, Substance Abuse and Mental Health Service Administration (SAMHSA). (2014). *Trauma-Informed Care in Behavioral Health Services, Treatment Improvement Protocol (TIP) (Series 57)*. Retrieved from <https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816>
- US National Research Council. (2010). *The prevention and treatment of missing data in clinical trials*. Committee on National Statistics, Division of Behavioral and Social Sciences and Education. Washington DC: National Academies Press
- US Veterans Health Administration (VHA) and the Department of Defense (DoD). (2017). *VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress* Retrieved from <https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGFinal012418.pdf>
- Ullman, S. E., Filipas, H. H., Townsend, S. M., & Starzynski, L. L. (2006). Correlates of comorbid PTSD and drinking problems among sexual assault survivors. *Addict Behav*, 31(1), 128-132. doi:10.1016/j.addbeh.2005.04.002
- Valeri, L., Sugarman, D. E., Reilly, M. E., McHugh, R. K., Fitzmaurice, G. M., & Greenfield, S. F. (2018). Group therapy for women with substance use disorders: In-session affiliation predicts women's substance use treatment outcomes. *J Subst Abuse Treat*, 94, 60-68. doi:10.1016/j.jsat.2018.08.008
- van Dam, D., Ehring, T., Vedel, E., & Emmelkamp, P. M. G. (2013). Trauma-focused treatment for posttraumatic stress disorder combined with CBT for severe substance use disorder: a randomized controlled trial. *BMC Psychiatry*, 13.
- van Dam, D., Vedel, E., Ehring, T., & Emmelkamp, P. M. G. (2012). Psychological treatments for concurrent posttraumatic stress disorder and substance use disorder: A systematic review. *Clinical Psychology Review*, 32(3), 202-214. doi:10.1016/j.cpr.2012.01.004
- van der Kolk, B. A. (2005). Developmental trauma disorder. *Psychiatric Annals*, 35(5), 401-408.

- van der Kolk, B. A. (2014). *The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma*. London: Allen Lane.
- van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *J Trauma Stress*, 18(5), 389-399. doi:10.1002/jts.20047
- van de Mark, N. R., Brown, E., Bornemann, A., & Williams, S. (2004). New directions for families: A family-oriented intervention for women affected by alcoholism and other drug abuse, mental illness and trauma. *Alcoholism Treatment Quarterly*, 22(3-4), 141-160. doi:[http://dx.doi.org/10.1300/J020v22n03\\_08](http://dx.doi.org/10.1300/J020v22n03_08)
- Vearey, J., Barter, C., Hynes, P., & McGinn, T. (2016). Research ethics in practice: Lessons from studies exploring interpersonal violence in different contexts. *Families, Relationships and Societies*. doi:10.1332/204674316x14673790283737
- Victor, S.E. & Klonsky, E.D. *J Psychopathol Behav Assess* (2016) 38: 582. <https://doi.org/10.1007/s10862-016-9547-9>
- Walby, A., & Allen, J. (2004). *Domestic violence, sexual assault and stalking: Findings from the British Crime Survey* (Home Office Research Study 276). Retrieved from the Home Office website: <https://webarchive.nationalarchives.gov.uk/20110218144416/http://rds.homeoffice.gov.uk/rds/pdfs04/hors276.pdf>
- Walker, T. (2013). Voices from the Group: Violent Women's Experiences of Intervention. *Journal of Family Violence*, 28(4), 419-426. doi:10.1007/s10896-013-9509-x
- Walker, T., Shaw, J., Turpin, C., Reid, C., & Abel, K. (2017). The WORSHIP II study: a pilot of psychodynamic interpersonal therapy with women offenders who self-harm. *The Journal of Forensic Psychiatry & Psychology*, 28(2), 158-171. doi:10.1080/14789949.2017.1301529
- Walsh, R. M., & Bruce, S. E. (2011). The relationships between perceived levels of control, psychological distress, and legal system variables in a sample of sexual assault survivors. *Violence Against Women*, 17(5), 603-618. doi:10.1177/1077801211407427
- Warshaw, C., Sullivan, C. M., & Rivera, E. A. (2013). *A Systematic Review of Trauma-Focused Interventions for Domestic Violence Survivors* Retrieved from the National Center for DV and Trauma website: [http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2013/03/NCDVTMH\\_EBPLitReview2013.pdf](http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2013/03/NCDVTMH_EBPLitReview2013.pdf)
- Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. (2013). *The PTSD Checklist for DSM-5 (PCL-5)*. Retrieved from [www.ptsd.va.gov](http://www.ptsd.va.gov).
- Weiss, C. (1997). *Theory-based evaluation: past, present, and future. New directions for evaluation*. San Francisco, CA: Jossey-Bass.
- Wells, S. Y., Morland, L. A., Torres, E. M., Kloezezan, K., Mackintosh, M.-A., & Aarons, G. A. (2017). The Development of a Brief Version of the Posttraumatic Cognitions Inventory (PTCI-9). Assessment. <https://doi.org/10.1177/1073191116685401>

- Whitehead, A. L., Julious, S. A., Cooper, C. L., & Campbell, M. J. (2016). Estimating the sample size for a pilot randomised trial to minimise the overall trial sample size for the external pilot and main trial for a continuous outcome variable. *Stat Methods Med Res*, 25(3), 1057-1073. doi:10.1177/0962280215588241
- Whittington, A. & Grey, N. (2014) Mastering meta-competence, the science and art of cognitive behavioural therapy in A. Whittington & N. Grey (Eds.) *How to Become and more effective CBT therapist: mastering meta-competence in clinical practice* (pp 3-16). West Sussex, UK: John Wiley and Sons Inc.
- Wilcox, P. (2012). Is parent abuse a form of domestic violence? *Social Policy and Society* 11(2):277-288.
- Willis, J. W. (2007). *Foundations of Qualitative Research*. Thousand Oaks, CA: Sage.
- Winhusen, T., Winstanley, E. L., Somoza, E., & Brigham, G. (2012). The potential impact of recruitment method on sample characteristics and treatment outcomes in a psycho-social trial for women with co-occurring substance use disorder and PTSD. *Drug and Alcohol Dependence*, 120(1-3), 225–228.
- Wolfe, J., & Kimerling, R. (1997). Gender issues in the assessment of posttraumatic stress disorder. In J. Wilson & T. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 192-238). New York: Guilford.
- Yeo, A., Legard, R., Keegan, J., Ward, K., McNaughton Nicholls, C., & Lewis, J. (2014). In-depth Interviews *Qualitative Research Practice: A guide for Social Science Students and Researchers* (2nd edition). London: Sage.
- Yehuda, R. (2002). Current status of cortisol findings in post-traumatic stress disorder. *Psychiatric Clinics of North America*. 25(2), 341-68.
- Zandberg, L. J., Rosenfield, D., Alpert, E., McLean, C. P., & Foa, E. B. (2016). Predictors of dropout in concurrent treatment of posttraumatic stress disorder and alcohol dependence: Rate of improvement matters. *Behaviour Research and Therapy*, 80, 1–9. <http://dx.doi.org/10.1016/j.brat.2016.02.005>.
- Zhou, X., & Hall, J. N. (2016). Mixed Methods Papers in First-Person and Third-Person: Writing Voices in Dialogue. *Journal of Mixed Methods Research*, 12(3), 344-357. doi:10.1177/1558689816652755
- Zlotnick, C., Johnson, J., & Najavits, L. M. (2009). Randomized Controlled Pilot Study of Cognitive-Behavioral Therapy in a Sample of Incarcerated Women With Substance Use Disorder and PTSD. *Behavior Therapy* 40(4), 325–336.
- Zvoch, K. (2009). Treatment fidelity in multisite evaluation. *American Journal of Evaluation*, 30(1), 44–61.

## **Appendix 1: Principles of trauma informed services**

(Elliot et al 2005)

Principle 1. Trauma-Informed Services Recognize the Impact of Violence and Victimization on Development and Coping Strategies

Principle 2. Trauma-Informed Services Identify Recovery From Trauma as a Primary Goal

Principle 3. Trauma-Informed Services Employ an Empowerment Model

Principle 4. Trauma-Informed Services Strive to Maximize a Woman's Choices and Control Over Her Recovery

Principle 5. Trauma-Informed Services Are Based in a Relational Collaboration

Principle 6. Trauma-Informed Services Create an Atmosphere That Is Respectful of Survivors' Need for Safety, Respect, and Acceptance

Principle 7. Trauma-Informed Services Emphasize Women's Strengths, Highlighting Adaptations Over Symptoms and Resilience Over Pathology

Principle 8: The Goal of Trauma-Informed Services Is to Minimize the Possibilities of Retraumatization

Principle 9. Trauma-Informed Services Strive to Be Culturally Competent and to Understand Each Woman in the Context of Her Life Experiences and Cultural Background

Principle 10. Trauma-Informed Agencies Solicit Consumer Input and Involve Consumers in Designing and Evaluating Services

## Appendix 2: Search strategies for scoping exercise, stage 1 and 2 searches.

Scoping exercise to identify published literature reviews on interventions to address post-traumatic stress and co-occurring substance use	
Databases	PsycINFO (From inception up until 19.02.16), MEDLINE (from inception up until 19.02.16), CINAHL (from inception up until 03.03.16), and the Cochrane Database of Systematic Reviews (03.03.16).
Search terms (see full list below)	Mixture of MESH and index terms of the keywords using Boolean operators for various terms relating to 1) PTSD OR “domestic or sexual violence or child abuse” AND 2) Substance misuse AND 3) psychological interventions OR mindfulness OR Yoga AND 4) Literature reviews
Inclusion criteria	<ul style="list-style-type: none"> <li>• Systematic search strategy employed to identify studies</li> <li>• The review assesses treatment interventions addressing 1) co-occurring substance use and PTS or 2) substance use amongst survivors of interpersonal violence</li> <li>• Includes psychological interventions, mindfulness or yoga interventions involving controlled trials</li> <li>• Reports on effectiveness of interventions for both Substance Use Outcomes <b>AND</b> PTS using clinician or validated self report measures</li> <li>• Report on studies whose sample involves adults 18yrs+</li> <li>• Reports on studies whose sample involves &gt;50% women</li> <li>• English language</li> </ul>
Exclusion criteria	<ul style="list-style-type: none"> <li>• Does not present outcome data for both PTS and substance use</li> <li>• Book chapters, books, dissertations</li> <li>• Only includes interventions which are perpetrator programmes</li> <li>• Only includes interventions evaluating pharmacology</li> </ul>
Outcome	The search yielded 2673 records after removal of duplicates. Titles and abstracts were reviewed by two reviewers (KB & GG/KT) with any disagreements brought to a third reviewer (GG/KT). The full texts of 28 reviews were retrieved and 20 reviews were excluded after reading the full text leaving a total of 8 reviews for inclusion into the principle searches.

Principle search strategies				
	Stage One			Stage 2
	Search 1: psychological interventions to reduce PTS and substance use among women with experiences of interpersonal violence	Search 2: Updated search of a comprehensive systematic review of psychological interventions	Search 3: mindfulness, meditation and yoga interventions to reduce PTS and substance use among women with experiences of interpersonal violence	Search 4: Process evaluations and secondary data analyses associated with studies included in searches 1-3
Data source	Eight literature reviews identified in initial scoping review (see above) <ul style="list-style-type: none"> <li>• Roberts, Roberts, Jones &amp; Bisson, 2015;</li> <li>• Bartlett et al., 2015;</li> </ul>	Searches conducted on the following databases from the upper limit search dates of the original review [01.01.14]:	Databases via Ovid: PsycINFO (inception-01.04.16), PubMed (inception-01.04.16), CINAHL (inception-01.04.16),	Ovid platform (combining searches in PsycINFO, MEDLINE, Embase) from database inception to 05.10.16. With PILOTS update on 19.04.18

	<ul style="list-style-type: none"> <li>• Najavits &amp; Hien, 2013;</li> <li>• van Dam, Vedel, Ehrling &amp; Emmelkamp, 2012;</li> <li>• Torchalla, Nosen, Rostam &amp; Allen, 2012;</li> <li>• Fowler &amp; Faulkner, 2011;</li> <li>• Fareed et al., 2013</li> <li>• Hesse, 2009</li> </ul>	<p>PsycINFO (01.01.14-08.03.16), PubMed (01.01.14 - 08.03.16), CINAHL (01.01.14-08.03.16), PILOTS (Up until 09.03.16) Clinicaltrials.gov (on 30.03.16). With update in PsycINFO, ClinicalTrials.gov &amp; PILOTS until 18.04.18</p>	<p>PILOTS (Up until 01.04.16) Clinicaltrials.gov (on 01.04.16). With update on PsycINFO, PILOTS &amp; Clinicaltrials.gov until 18.04.18</p>	<p>Reference lists of retrieved papers were also checked.</p> <p>Websites  US Substance Abuse and Mental Health Services Administration (<a href="http://www.samhsa.org">www.samhsa.org</a>)  National Drug and Alcohol Research Centre University of New South Wales (<a href="http://www.ndarc.med.unsw.edu.au">www.ndarc.med.unsw.edu.au</a>)  Institute for Health and Recovery (<a href="http://www.healthrecovery.org">www.healthrecovery.org</a>)  British Columbia Centre for Excellence in Women's Health <a href="http://www.bccwh.bc.ca">www.bccwh.bc.ca</a>  <a href="http://www.treatment-innovations.org">www.treatment-innovations.org</a>  <a href="http://www.stephaniecovington.com">www.stephaniecovington.com</a>  <a href="http://www.advancedtrauma.com/News-and-Publications.html">http://www.advancedtrauma.com/News-and-Publications.html</a></p> <p>Where no supplementary studies were identified by these means authors of eligible primary studies were contacted to ask if there were any additional papers relating to their study.</p>
Search terms (see full list below)	N/A	1) PTSD OR "domestic or sexual violence or child abuse" AND 2) substance misuse AND 3) psychological interventions AND 4) Controlled trials	1) PTSD OR "domestic or sexual violence or childhood abuse" AND 2) Substance Misuse AND 3) meditation OR yoga OR mindfulness AND 4) Controlled trials	Entering the name of the intervention or primary study as a keyword.
Inclusion criteria	<ul style="list-style-type: none"> <li>• Any psychological intervention addressing 1) co-occurring substance use and PTS or 2) substance use amongst survivors of interpersonal violence</li> <li>• Involves primary studies or secondary data analysis of a controlled trial (randomised and non randomised)</li> <li>• Reports on effectiveness of interventions on both substance</li> </ul>	<ul style="list-style-type: none"> <li>• Any psychological intervention addressing 1) co-occurring substance use and PTS or 2) substance use amongst survivors of interpersonal violence</li> <li>• Involves primary studies or secondary data analysis of a controlled trial</li> </ul>	<ul style="list-style-type: none"> <li>• Any form of meditation, mindfulness or yoga practice* addressing 1) co-occurring substance use and PTS or 2) substance use amongst survivors of interpersonal violence</li> <li>• Involves primary studies or secondary data analysis of a controlled trial (randomised and non randomised)</li> </ul>	<ul style="list-style-type: none"> <li>• Quantitative studies (inc. secondary data analysis) relating to a primary study identified in searches 1-3</li> <li>• Qualitative studies relating to a primary identified in searches 1-3</li> <li>• Explores the following research question:</li> <li>• For whom does the delivered intervention produce change (subgroups), how (Mechanisms) and under what contexts (factors external to the intervention and implementation considerations)?</li> </ul>

	<p>use outcomes and PTSD using clinician or validated self report measures</p> <ul style="list-style-type: none"> <li>• Sample involves adults 18yrs+</li> <li>• Sample involves &gt;50% women</li> </ul>	<p>(randomised and non randomised)</p> <ul style="list-style-type: none"> <li>• Reports on effectiveness of interventions on both substance use outcomes and PTSD as primary or secondary outcomes using clinician or validated self report measures</li> <li>• Sample involves adults 18yrs+</li> <li>• Sample involves &gt;50% women</li> </ul>	<ul style="list-style-type: none"> <li>• Reports on effectiveness of Interventions on substance use outcomes and PTS using clinician or validated self report measures</li> <li>• Sample involves adults 18yrs+</li> <li>• Sample involves &gt; 50% of women participants</li> </ul> <p>* including mindfulness based CBT when compared to CBT only.</p>	<ul style="list-style-type: none"> <li>• Peer reviewed and non-peer reviewed publications, grey literature and material produced online, published and unpublished material.</li> </ul>
Limits	English language	English language	English language	English language
Exclusion criteria	<ul style="list-style-type: none"> <li>• Trauma of participants limited to non-interpersonal trauma (e.g combat, accident, terrorist attack etc)</li> <li>• Pharmacological interventions</li> <li>• Non-controlled interventions, case studies</li> </ul>	<ul style="list-style-type: none"> <li>• Trauma of participants limited to non-interpersonal trauma (e.g combat, accident, terrorist attack etc)</li> <li>• Pharmacological interventions</li> <li>• Book chapters, books, dissertations</li> <li>• Non-controlled interventions, case studies</li> <li>• Literature reviews</li> <li>• Mind-body interventions</li> </ul>	<ul style="list-style-type: none"> <li>• Trauma of participants limited to non-interpersonal trauma (e.g combat, accident, terrorist attack etc)</li> <li>• Pharmacological interventions</li> <li>• Book chapters, books, dissertations</li> <li>• Non-controlled interventions, case studies</li> <li>• Literature reviews</li> </ul>	<ul style="list-style-type: none"> <li>• Book chapters, dissertations or conference proceedings</li> <li>• Included in searches 1-3</li> </ul>

## Full search terms for PsycINFO (via Ovid)

Literature review

1. Literature review/

Meta Analysis/(Literature or Systematic) and Review\*

2. Evidence adj2 Synthesis

3. Review adj2 evidence

4. or Meta-analysis or).mp

PTSD

1. PTSD or post-trauma\* or post trauma\* or posttrauma\* or stress disorder\*

2. (trauma\* and (psycho\* or stress\* or complex))

3. (stress\* and (extreme or disorder\*))

4. DESNOS

5. Posttraumatic Stress Disorder/

6. Complex and (PTSD or post-trauma\* or post trauma\* or posttrauma\*)

1 or 2 or 3 or 4 or 5 or 6

Domestic or sexual violence or child abuse

1. Domestic violence/

2. Battered females/

3. Child Abuse/

4. Emotional abuse/

5. Exposure to violence/

6. Family conflict/

7. Intimate Partner Violence/

8. Marital conflict/

9. Partner Abuse/

10. Physical Abuse/

11. Sexual Abuse/

12. Domestic and (violence or abuse)

13. (Physical or emotional or psychological or financial) and abuse

14. Intimate partner and (violence or abuse)

15. Sexual and (Assault or abuse).mp

16. Rape.mp

17. Sexual exploitation.mp

18. Coercive control.mp

19. Trauma\*.mp

20. Gender\* adj violence



21. ((abus\$ OR batter\$ OR violen\$ OR beat\$) adj5 (domestic OR partner\$ OR family OR families OR spouse OR woman OR women OR men OR man OR female\$ OR male\$ OR wife OR wives OR husband\$ OR boyfriend\$ OR girlfriend\$ OR elder\$ OR brother\$ OR sister\$ OR father\$ OR mother\$ OR daughter\$ OR son\$ OR carer\$).mp.)

1 or 2 or 3 or 4 or 5 or 6 or 7 pr 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21

#### Substance misuse

1. exp drug abuse/

2. exp Alcohol Abuse/

3. ("substance use disorder\*" or SUD)

4. (drug or alcohol) and abuse

5. (abuser\* or abusing or addict\* or depend\* or habit\* or misuse or user\*).

6. (adinazolam or aerosol\* or alcohol\* or alprazolam or amphetamin\* or anthramycin or anxiolytic\* or ativan or barbituat\* or bentazepam or benzodiazepin\* or bromazepan or brotizolam or buprenorphin\* or camazepam or cannabi\* or chlordiazeoxid\* or cinolazepam or clobazam or clonazepam or clorazepam or clotiazepam or cloxazolam or cocaine\* or codeine or crack or crystal or cyprazepam or depressant\* or diacetylmorphin\* or diazepam\* or doxefazepam or ecstasy or estazolam or etizolam or fentanyl or flunitrazepam or flurazepam or flutazoram or flutoprazepam or fosazepam or gases or GHB or grisopam or halazepam or hallucinogen\* or haloxazepam or heroin\* or hydromorphone or hydroquinone or hypnotic\* or inhalant\* or ketamin\* or ketazolam or librium or loflazepate or loprazolam or lorazepam or lormetazepam or LSD or marihuana\* or marijuana\* or MDMA or meclonazepam or medazepam or meperidine or mephedrone or mescaline\* or metaclozepam or methadone or methamphetamine\* or methaqualone or mexazolam or midazepam or midazolam or morphine\* or narcotic\* or nerisopam or nimetazepam or nitrazepam or nitrites or "nitrous oxide" or "n-methyl-3,4-methylenedioxyamphetamine" or nordazepam or opiate\* or opioid\* or opium or oxazepam or oxazolam or oxazepam or oxycodone or oxzepam or painkiller\* or "pain killer\*" or PCP or pethidin\* or phencyclidin\* or pinazepam or prazepam or propazepam or propoxyphene or psilocybin or psychedelic\* or psychoactive\* or psychostimulant\* or quinazolinone or ripazepam or ritalin or sedative\* or serazepam\* or solvent\* or steroid\* or stimulant\* or substance\* or temazepam or tetrazepam or tofisopam or tramadol or triazolam or trifluazepam or valium or vicodin).

7. (drug\* and (recreational or street)).

8. 1 or 2 or 3 or 4 or 5 or 6 or 7

#### Psychological interventions

1. psychotherapy/ or behavior therapy/ or brief psychotherapy/ or client centered therapy/ or cognitive behavior therapy/ or eye movement desensitization therapy/ or feminist therapy/ or gestalt therapy/ or group psychotherapy/ or humanistic psychotherapy/ or individual psychotherapy/ or integrative psychotherapy/ or interpersonal psychotherapy/ or narrative

therapy/ or psychoanalysis/ or psychodynamic psychotherapy/ or psychotherapeutic counseling/  
or relationship therapy/ or solution focused therapy/ or supportive psychotherapy/ or transactional  
analysis/ or cognitive therapy/ or couples therapy/

2. treatment/ or cognitive techniques/ or personal therapy/ or or treatment outcomes/ or  
intervention/ or group intervention/ or exp counseling/ or counseling psychology/ or family therapy/  
or or support groups/ or psychoeducation/

3. treatment or interventions or psychotherap\* or psychosocial\* or "behavior therap\*" or  
"behaviour therap\*" or "exposure therap\*" or "EMDR" or "narrative therap\*"

#### Mindfulness/Yoga

1. exp Meditation/ or meditation. ti,ab,id.

2. exp Mindfulness/ or or mindful\*. ti,ab,id

3. (Vipassana or Zen or Sudarshan or Kriya or Anapanasathi or ChunDoSupBup or Qigong).  
ti.ab.id

4. exp Yoga/

5. (yoga or pranayama or asana or yogic). ti,ab,id

#### Controlled trials

1. exp clinical trial

2. Randomi#ed controlled trial\$.t i, ab, id.  
controlled trial. ti, ab, id

3. randomi#ed or trial or randomly or control. ti, ab, id

### Appendix 3: Sub-codes created in the narrative review using thematic analysis

Subgroups	Mechanisms of impact	Contexts	Implementation considerations
Race/ethnic diversity	Coping Skills	On-going victimisation	Adverse events
Co-occurring psychiatric conditions	Attending to the relational	Wrap-around services	Staff skills
On-going victimisation	Mediators	Trauma informed practice	Group-work
Physical health problems	Exposure	Systems	Length of interventions
Improved PTSD at follow up	Connection with others	Social Support/Networks	Staff self-care
Improved substance use at follow up	Self-identity	Service user involvement	Aids to retention
Severe PTSD at baseline	Self-worth	Case Management	Reasons for attrition
Severe substance use at baseline	Therapeutic Alliance	Gender specific services	Women's views on treatment satisfaction
	Emotional regulation	Impediments to recovery	
	Mindfulness		

## Appendix 4: Overview of trauma-specific models identified in the systematic review

Model name	Content
<b>Past-focused: Prolonged Exposure &amp; Cognitive Behavioural Therapy</b>	
Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE)	Individual sessions. Motivational enhancement and CBT for substance use (sessions 1-4 and throughout); psychoeducation relating to both disorders and their interaction (sessions 1-4); in-vivo exposure (sessions 5-12); imaginal exposure (sessions 6-12); and cognitive therapy for PTSD (sessions 8-12); treatment review, after-care planning, and termination of therapy (session 13).
Integrated Cognitive Behavioural Therapy for PTSD and AUD	Individual sessions. Sessions 1-2: Preparation for treatment, motivational interviewing, brief account of trauma, monitoring tasks; Sessions 3-4: Assessing high risk situations, coping with cravings, PTSD psychoeducation, introducing exposure elements  Sessions 5-6: identifying trauma-related cognitive distortions and alcohol and drinking thoughts, prolonged imaginal exposure (recounting the traumatic memory in the present tense for a minimum of 45 mins), intro to in-vivo exposure; Sessions 7-9: managing negative moods, pleasant events scheduling, cognitive restructuring for PTSD, imaginal exposure, in-vivo exposure practice Sessions 10-12: managing thoughts about alcohol, cognitive restructuring, imaginal exposure, in-vivo exposure practice, personal lapse plan, review consolidation & termination.
<b>Past-focused: Other exposure based interventions</b>	
Trauma focused imaginal exposure	Individual sessions. 1 educational session & 6 PTSD exposure sessions (1hr) (preceded and followed by a laboratory cue exposure). Participants were encouraged to include emotions and cognitions in their verbal description of the event. Participants described their trauma repeatedly and continuously over the course of the six 60-min clinical sessions. Each session was audiotaped, and participants were instructed to listen to the tape daily.
Substance Dependency-Post-Traumatic Stress Disorder Therapy (SDPT)	Individual sessions. Phase 1 (weeks 1-12) Coping skills treatment for addictions, integrated with psycho-education about PTSD. Phase 2 (weeks 13-20) PTSD symptom-focused

	treatment (Stress Inoculation Therapy & Exposure), with continuing attention to substance use.
Eye Movement Desensitisation and Reprocessing (EMDR) Therapy	Individual sessions. Session 1: Assessment of readiness and treatment plan development, identification of traumatic stressful memories for processing; Session 2: Imagery and stress reduction techniques to deal with emotional distress; Session 3-7 EMDR using bilateral stimulation involving taps or tones targeting the visual vivid memory, negative belief about self, related emotions and body sensations and positive beliefs; Session 7-8 closure and examination of progress.
<b>Present-focused interventions</b>	
Integrated Cognitive Behavioural Therapy for PTSD (ICBT)	12-14 Individual sessions. Module 1: Introduction to treatment - outline of therapy, goals and mutual expectations; Module 2: Crisis and Relapse Prevention plan - review early warning signs, coping strategies and social supports; Module 3: Breathing retraining - anxiety reduction skill. Module 4: Education on PTSD; Module 5: PTSD Associated symptoms - fear & anxiety, sadness & depression, guilt & shame, anger, interpersonal consequences of PTSD, interplay with PTSD and substance use; Module 6: Cognitive restructuring part 1- basic framework for identifying stressful situations, beliefs/thoughts and emotional and behavioural consequences; Module 7: Steps to dispute belief, generating alternative emotions or behaviours; Module 8: Closure to therapy, aftercare plan.
Trauma Adaptive Recovery Group Education and Therapy (TARGET)	8-9 groupwork sessions. Phase 1: stabilisation and self-regulation via 'Focusing'; Phase 2: trauma processing via 'Recognising' emotions and cognitive evaluations, goal definitions and options focused on current life experiences, Phase 3: incorporates learning into client's overarching lifestyle, values, goals and plans.
Seeking Safety	25 sessions, groupwork/individual: (1) Cognitive topics x 7 (PTSD, Compassion, Creating Meaning, Discovery, Recovery Thinking, When Substances Control You, Integrating the Split Self) (2) Behavioural topics x 7 (Taking Good Care of Yourself, Self-Nurturing, Grounding, Red and Green Flags, Commitment, Coping with Triggers, Respecting your Time) (3) Interpersonal topics x 7 (Asking for Help, Setting Boundaries, Healthy Relationships, Getting Others to Support Your Recovery,

	Honesty, Community Resources, Healing from Anger) (4) Combination x3 (Safety, Review, Termination) (5) Case management x 1 (and running throughout the programme delivery) assumes that psychological interventions can only work if individuals have an effective and holistic coordinated care plan.
Trauma Recovery and Empowerment Model (TREM)	33 groupwork sessions comprising psychoeducational, cognitive behavioral, and relational elements that emphasizes survivor empowerment. Divided into four areas: 11 x Empowerment; 9x Trauma Recovery; 8 x Advanced Trauma Recovery Issues; and 3 x Closing Rituals.
Gender Responsive Treatment	28 Groupwork sessions. Phase 1 Helping Women Recover (Covington 2008) (17-sessions) organized into four modules: (1) Self module, including impacts of addiction (2) Relationship module (3) Sexuality module including link between with addiction and body. (4) Spirituality module. Phase 2 Beyond Trauma (Covington, 2003) consists of 11 sessions focused on three areas: teaching women what trauma and abuse are, helping them to understand typical reactions to trauma and abuse, and developing coping skills, impact of abuse on their lives personal safety.
Relapse Prevention and Relationship Safety: Women's Wellness Programme	Session1: Preparing for treatment, enhancing motivation. Session 2: Relationship safety, assessing risk, safety planning and case management (individual). Session 3: Triggers for relationship conflict and drug use. Session 4: Healing from psychological domestic violence. Session 5: Dealing with physical domestic violence, reconstructing anger. Session 6: Recovering from trauma, identifying PTSD triggers. Session 7-8: Setting sexual boundaries, negotiation skills, identifying riggers for HIV. Session 9: Strategies for reducing HIV risk. Session 10: Rethinking the balance of power. Session 11: Avoiding Relapse to unsafe behaviours. Session 12: Recovery and celebrating successes.

Dual Assessment and Recovery Track (DART)	12 individual and groupwork sessions incorporated into modified Therapeutic Community treatment and comprising 3 elements: 1) trauma informed addiction treatment to address links to substance misuse and trauma, developing copings skills 2) psycho-social seminar to improve client's understanding of mental health 3) teaching of case management skills to help capacity to negotiate with health and social agencies on their own behalf.
Mindful Awareness in Body Orientated Therapy (MABT)	Individual sessions. Sessions 1 & 2 focused on massage with body literacy - the practice of identifying and articulating what is noticed in the body. Sessions 3 & 4 interoception through body awareness exercises. Sessions 5-8 mindful body awareness practice a) interoceptive awareness of a specific area within the body b) sustained mindful present-moment awareness in the body c) intermittent attention to specific aspects of sensory awareness (sensation, image, emotion and form), review and homework practices.
Integrated and trauma-informed treatment with trauma-specific interventions [Women and Co-occurring Disorders and Violence (WCDV) Multi-site Study]	9 sites implementing groupwork programmes either Seeking Safety(n=4), TREM (n=3 (described above) or Addictions and Trauma Recovery Integrated Mode (ATRIUM)I (n=1); Triad Women's Group (n=1). In addition, all interventions sites delivered other trauma informed group-work programmes, outreach and engagement, screening and assessment, parenting skills training, resource coordination and advocacy, crisis intervention and peer run services, and often included additional groups such as domestic violence, leadership, health and employment.

## **Appendix 5: Inclusion/Exclusion criteria used for recruiting the interview sample from England**

Online networks/lists used in the recruitment: CONNECT Centre for International Research on Interpersonal Violence and Harm, PROGRESS-National Consortium of Consultant Nurses in Dual Diagnosis, National Centre for the Study and Prevention of Violence and Abuse, Drug Misuse Research JISCMAIL, Alcohol Misuse JISCMAIL, Gender Violence JISCMAIL, AGENDA Alliance for Women and Girls at Risk, Domestic Violence and Health Network);

Inclusion criteria: practitioners delivering 1:1 or group-work interventions to women that address the co-occurring issues of substance use, IPA and PTSD symptoms.

Exclusion criteria: Practitioners providing only practical support and/or advocacy (e.g. Domestic Violence Advisors) or required abstinence from service users to access the intervention, and/or were not based England.

Initial recruitment material identified the following practice models of interest:

(1) manualized trauma-specific interventions which address both substance use and PTSD symptoms [e.g. Seeking Safety (Najavits, 2002); TREM (Harris & Fallot, 2002); Trauma-focused CBT) (e.g. Ehlers et al., year ); (2) any other trauma-based practice or interventions developed 'in-house' with women who use substances; (3) other gender specific treatments addressing the co-occurring issues among women .



## Appendix 6: Confirmation of ethics approval from Kings College London

Research Ethics  
Office

Franklin Wilkins Building  
5.9 Waterloo Bridge Wing  
Waterloo Road  
London SE1 9NH  
Telephone 020 7848 4020/4070/4077  
reo@kcl.ac.uk



Karen Bailey

13 January 2016

Dear Karen,

LRS-15/16-1921 - Understanding what works to address problematic substance use and psychological distress amongst women with experiences of domestic and sexual violence: a qualitative study of service practitioners'

Thank you for submitting your application for the above project. I am pleased to inform you that your application has now be approved with the provisos indicated below:

1. Section C2: It is assumed that the scoping e-mail will be sent from your College address.
2. Information Sheet:
  - i. Insert the paragraph beginning with 'If this study has harmed you in any way...' before the contact details for your academic supervisor.
  - ii. Remove 'track changes'.

All changes must be made before data collection commences. The Committee does not need to see evidence of these changes, however supervisors are responsible for ensuring that students implement any requested changes before data collection commences.

Please ensure that you follow all relevant guidance as laid out in the King's College London *Guidelines on Good Practice in Academic Research*:  
<http://www.kcl.ac.uk/college/policyzone/assets/files/research/good%20practice%20Sept%2009%20FINAL.pdf>

Ethical approval has been granted for a period of **three years** from 13 January 2016 . You will not be sent a reminder when your approval has lapsed and if you require an extension you should complete a modification request, details of which can be found here:  
<http://www.kcl.ac.uk/innovation/research/support/ethics/applications/modifications.aspx>

Any unforeseen ethical problems arising during the course of the project should be reported to the panel Chair, via the Research Ethics Office.

Please note that we may, for the purposes of audit, contact you to ascertain the status of your research.

We wish you every success with your research.

Yours sincerely,

PNM Research Ethics Panel REP Reviewer

## Appendix 7: Confirmation of ethics approval from South London and Maudsley NHS Foundation Trust

Institute of  
Psychiatry,  
Psychology &  
Neuroscience

Research and  
Development  
Office

Box P005  
De Crespigny Park  
Denmark Hill  
London SE5 8AF  
Tel +44 (0)20 78480790  
Fax +44(0)20 78480147  
<http://www.kcl.ac.uk/ioppn/research/office/index.aspx>



Ms Karen Bailey  
Institute of Psychiatry, Psychology and Neuroscience  
King's College London  
Addiction Sciences Building  
4 Windsor Walk, Denmark Hill SE5 8BB

22<sup>nd</sup> April 2016

Dear Ms Bailey

**Trust Approval: R&D2016/028**

**Title: Understanding what works to address problematic substance use and psychological distress amongst women with experiences of domestic and sexual violence: A qualitative study of service practitioners' and researchers' experiences.**  
**REC Reference: LRS-15/16-1921**

I am writing to confirm approval for the above research project at South London and Maudsley NHS Foundation Trust. This approval relates to work in the Addictions CAG and to the specific protocol and informed consent procedures described in your R&D Form. Any deviation from this document will be deemed to invalidate this approval. Your approval number has been quoted above and should be used at all times when contacting this office about this project.

Amendments, including extending to other Trust directorates will require further approval from this Trust and where appropriate the relevant Research Ethics Committee. Amendments should be submitted to this R&D Office by completion of an R&D Amendment form together with any supporting documents. A copy of this is attached ([R and D Amendment Form V3.doc](#)), but is also available on the R&D Office website.

[King's College London - Research and development approval](#)

I can confirm that King's College London and South London and Maudsley NHS Foundation Trust will be taking on the role of Sponsor for this study.

Approval is provided on the basis that you agree to adhere to the Department of Health's Research Governance requirements including:

- Ethical approval must be in place prior to the commencement of this project.
- As Chief Investigator and/or Principal Investigator for this study you have familiarised yourself with, and accept the responsibilities commensurate with this position, as outlined in the Research Governance Framework

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4122427.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4122427.pdf).

## Appendix 8: Confirmation of ethics approval from Camden and Islington NHS Foundation Trust



1st Floor, Bloomsbury Building  
St Pancras Hospital  
4 St Pancras Way  
NW1 0PE

Tel: 020 3317 3045  
Fax: 020 7685 5830/5788  
www.noclor.nhs.uk  
06 July 2016

Ms Karen Bailey  
National Addictions Centre, IOPPN  
Kings College London  
4 Windsor Walk, London  
SE5 8BB

Dear Ms Karen Bailey,

I am pleased to confirm that the following study has now received R&D approval, and you may now start your research in the trust(s) identified below:

<b>Study Title:</b> Understanding what works to address problematic substance use and psychological distress amongst women with experiences of domestic (DV) and sexual violence (SV): a qualitative study of service practitioners' and researchers' experiences <b>R&amp;D reference:</b> 204083 <b>REC reference:</b> N/A		
Name of the trust	Name of current PI/LC	Date of permission issue(d)
Camden & Islington NHS Foundation Trust	[Redacted]	06 July 2016
If any information on this document is altered after the date of issue, this document will be deemed INVALID		

Specific Conditions of Permission (if applicable)
If any information on this document is altered after the date of issue, this document will be deemed INVALID

Yours sincerely,

Pushpsen Joshi  
Research Operations Manager

Cc: Principle Investigator(s)/Local Collaborator(s), Sponsor Contact

## Appendix 9: Practitioners topic guide used in stakeholder interviews

(USA & England)

### 1. Introduction

- Introduction to researcher and National Addiction Centre
- PhD topic
- Explanation of aims and objectives of study
- Explanation of confidentiality and options for anonymity
- Explain length of interview, nature of recording and how the data will be stored
- Go through consent form
- Check if there are any questions
- Check they are happy to continue

### 2. Background

Aim: to find out contextual information about the participants role in relation to the topic matter

- Overview of organisation
- Role of practitioner
- Description of the service and programmes aimed at women with co-occurring issues with which the participant is involved
- Explore adherence to or adaptations from a manualised programme or influences from other programmes
- Service user profile: psychiatric co-morbidities (dual diagnosis), exposure to historic and/or ongoing violence, socio-demographics
- Explore how women are assessed for these issues.

### 3. Theories of change

Aim: to identify key theories of change for improving outcomes for women with experiences of interpersonal abuse, problematic substance use and PTSD symptoms.

- Explore views on researcher theories about interplay between mental health, substance use and experiences of violence:
  - (1) survivors of childhood abuse, domestic and sexual violence, domestic violence require unique responses to addressing PTSD symptoms compared to survivors of other types of trauma.
  - (2) Substances are used as coping mechanisms for symptoms of PTSD
  - (3) On-going experiences of abuse interfere with successful engagement and completion of drug/alcohol treatment and PTSD treatment
  - (4) Individuals who are traumatised (e.g. hyper-alert, hyper arousal) and in constant state of fight or flight are less able to implement safety planning which may lead to increased risk.
- Rationale for chosen program
- Thoughts on how the programme model leads to recovery– e.g.

*“What is it about this programme that is particularly important to this group of women?”*

*“What is it about the service environment, staff etc. that may interact with the intervention to optimise outcomes for women?”*

- Identification of intermediary level outcomes that need to be in place before longer term outcomes can be obtained
- Identification of other service components that are required to support these processes
- Identification of aspects of their programme that perhaps do not work so well or may benefit from further modifications.

- Impacts of wider contextual factors and competing causal mechanisms – e.g. “*What things help or hinder your work with women?*”  
“*What are possible constraints to the program working for any of the women?*”
- Is the intervention better suited to certain subgroups of women
- Explore other individual needs that must be fulfilled for a woman to benefit

#### **4. Trauma informed and trauma-specific services**

Aim: To explore understandings of trauma informed practice

- Explore participant understanding of trauma informed practice
- Explore how their service is trauma informed

(Prompts)

- Safety
- Concepts of Trust
- Strengths based empowerment modalities
- Staff training and skills
- Clinical Infrastructure
- Organisational policies and procedures
- Partnership working and collaborative service delivery e.g referral pathways and wrap around services

Aim: to explore views on integrated trauma-specific interventions and core components.

- Explore views on how PTSD treatment should be delivered to this client group
- Explore views on core components
- Experience of and views about exposure based therapies
- Gain views on the opportunities to integrate trauma-specific interventions into current service delivery and perceived challenges.

#### **4. Implementation process**

Aim: to generate key learning to enhance effective implementation of a new intervention as part of a study.

- Staffing requirements (experience, skills)
- Supervision
- Partnership working with other sectors
- Logistical aspects of service delivery – e.g. groupwork, 1:1, open/closed group, length, financial support for travel, childcare etc
- Other facilitators or barriers to effective implementation

## **Appendix 10: Researcher topic guide used in stakeholder interviews**

### **1. Introduction**

- Introduction to researcher and National Addiction Centre
- PhD topic
- Explanation of aims and objectives of study
- Explanation of confidentiality and options for anonymity
- Explain length of interview, nature of recording and how the data will be stored
- Go through consent form
- Check if there are any questions
- Check they are happy to continue

### **2. Current state of literature**

Aim: to discuss the current state of the literature with regards to the effectiveness of integrated treatment approaches, with a focus on that undertaken by researcher

- What overall learning can be harnessed from the last ten years of evaluation of integrated approaches
- Possible explanations for variation in treatment effects found in RCTs (beyond internal validity)
- Identification of active components found in controls (e.g focus on body in Women's Health Education)
- Certain subgroups of women found to benefit both ( refer to studies by Hien et al., 2009; Swope et al., 2010). ]
- Conflicting evidence base to support hypothesis of drug/alcohol use as a coping mechanism.

### **3. Theories of change**

Aim: to explore understandings of theories of change in programmes undertaken in evaluation

- Explore views on theories about interplay between mental health, substance use and experiences of violence:

(1) survivors of childhood abuse, domestic and sexual violence, domestic violence require unique responses to addressing PTSD symptoms compared to survivors of other types of trauma.

(2) Substances are used as coping mechanisms for symptoms of PTSD

(3) On-going experiences of abuse interfere with successful engagement and completion of drug/alcohol treatment and PTSD treatment

(4) Individuals who are traumatised (e.g. hyper-alert, hyper arousal) and in constant state of fight or flight are less able to implement safety planning which may lead to increased risk

- Identification of key programme and service components
- Components representing the most complex changes to practice
- Contextual contingencies
- Competing causal mechanisms
- Are certain interventions better suited to certain subgroups of women
- Key uncertainties that still need to be addressed

### **4. Implementation**

Aim: To explore implementation and process related issues revealed in previous studies

- The complexities of evaluating these interventions in a real world setting.
- Role of trauma informed service in which the specific intervention is situated
- For which components do previous studies, or feasibility testing stages, indicate the greatest uncertainty regarding how to deliver them in routine practice?
- Considerations for measuring the wider contextual and environmental factors which may influence the outcomes of the intervention – measurement tools recommended
- Recommendations for outcome measurement tools
- Practical instruments available to assess adherence and competence of the practitioners use of the intervention's core components (fidelity)

## Appendix 11: Initial codebook used for the qualitative interview data with practitioners in England

High level code	Description
Current service model	How the service operates, different components and elements of interventions
Evidencing practice	Outcome measurement, mention of evidence base interventions
External Challenges	Challenges externally to the intervention which impact on the service delivery or the wider support for clients e.g., funding, exclusion criteria for mental health services, stigma
Establishing Self-identity	Activities to establish identity, sense of self, beyond trauma victim, training/volunteering/mentoring, service user involvement
Implementation considerations	Considerations for engagement and attrition, staff skills/training, logistics, internal challenges
Important intervention components	Different content for groupwork or individual work, stages, or types of therapeutic approaches, types of strategies, symptoms to target, why these may be good, challenges
Important service attributes	Issues related to characteristics of a service, service philosophy, characteristics of staff
Interpersonal and PTSD	Impacts of abuse, neurobiology of trauma, views on how type of trauma impacts on the response
Intersectionality	Cultural competence, issues to consider relating to forms of multiple disadvantage, intersecting equality and diversity issues
Links between substance use, PTS and violence	Practitioners views on the theories linking these issues
Links between violence and wider mental health	Practitioners views on the theories linking these issues – relating to other mental health conditions e.g. depression, BPD etc



Mechanisms of action	Views on moderators, mediators between intervention and PTS and substance use improvement, what needs to change, how are changes achieved
Partnership working	Referral pathways, multi-disciplinary working, collaboration
Research considerations	Issues relating to fidelity, how to conduct a study on a trauma informed intervention
Safety	Examples of practice which focuses on establishing safety – physical and emotional, external/internal.
Service user profile	Demographics, substance use, experiences of violence, mental health
Trauma informed care	Mention to wider organisation systems relating to implementing trauma informed care
Views on exposure work	Views about exposure/memory processing treatments; strengths/weakness for this client group, what works/doesn't work
Working with victims of intimate partner violence	Particular considerations for working with victims of partner violence with substance use

## Appendix 12: Initial codebook used for the qualitative interview data with practitioners in USA

Code	Description	Examples of Sub-codes
Implementation considerations	Relates to learning regarding the implementation of researching a manualised group-work programme; reasons for choice of intervention, group format, retention/engagement, adapting material, staff skills, resources, wrap-around care.	Coordinating care, wrap-around services, staff skills, staff diversity, accessibility of materials, strengths of interventions, limitations of interventions, adaptations, expressive therapies, body-based therapies,
Context	Factors specific to the characteristics of the participants, or to the service, including US treatment system considerations, which may influence the delivery of the programme.	Ongoing-violence, service ethos, public health system, client diversity, grant funded projects, lack of access to primary healthcare, diagnoses, 12 step, trauma-informed practice, community base.
Research considerations	Considerations for the Phase 3 & 4 of PhD study in terms of design or conduct of the feasibility study e.g. learning from trials.	Measures, frequency of assessment, realistic expectations of change, short-term treatments, suggestions from practitioners, fidelity, exclusion criteria.

## Appendix 13: Proposed amendments to the Seeking Safety hand-outs

*N.B The most important proposed changes are indicated in bold and starred*

Item No.	Page numbers	Proposed change	Rationale
1	Throughout the manual	<b>Replace all references to “substance abuse” with “problematic substance use” or “substance misuse” *</b>	<b>The term “substance abuse” is not used in the UK and the use of the term ‘abuse’ runs counter to philosophical approaches to working with client group whom the study is aimed at i.e. women who have experienced interpersonal violence and abuse</b>
2		Replace use of “treatment” with “programme/intervention”	More akin to language used in substance misuse services here
3		<b>Replace use of word “disorder” (when used by itself) to problem/issue*</b>	<b>More akin to language used in substance misuse services here</b>
4		Check-in-Check out: change term “commitment” – to “action/intention”	Terminology better fits with ethos of service delivery partner
5		<b>Change reference to AA – to “peer support groups” *</b>  <b>Where there are references to “call a sponsor” add “or a safe friend” *</b>	<b>AA is not as dominate here in the UK as in the USA and we have other forms of peer support. Emphasis on this as the only form of peer support can be off putting to some. Some women who have been abused have reported particularly bad experiences with this approach so want to avoid alienating this client group.</b>
6		<b>Replace references to “physical self-abuse” to “self harm” *</b>	<b>Wish to avoid language of physical “self abuse” amongst survivors of interpersonal abuse - runs counter to treatment philosophy for working with this client group.</b>
7		Increase font size and layout of text to make it easier to read	Based on feedback from service users reviewing the manual
8	p101 <b>Safety</b>	No additional changes	
9	p118 <b>PTSD: Taking Back Your Power</b> – Handout 1	<b>(1) Change text to reflect DSM-V criteria for PTSD *</b>  (2) Replacing PTSD prevalence stats with ones from UK samples. (3) Adding in an example of a UK famous person (Mick Jagger) who had PTSD.	<b>(1) To bring into line with latest definition of PTSD. This study will be assessing people using DSM-V criteria so do not want to confuse people with slightly different assessment.</b>  (2) & (3) More culturally relevant  (4) Better matches treatment philosophy of service delivery partners.

		(4) Remove "it is a psychiatric illness" in the line which begins <i>PTSD is considered an anxiety disorder</i>	
10	p121 <b>PTSD: Taking Back Your Power</b> – Handout 3	In section beginning <i>Can't stop using substances – compassionate view</i> remove last sentence "Substance abuse is a medical illness." *	Service delivery partners to do not work to this understanding/philosophy of substance misuse
11	p122 <b>PTSD: taking Back Your Power</b> – Handout 4	Replace "Long term PTSD Problems" with "Complex PTSD"	Complex PTSD is the term more akin to treatment language in UK.
12	p135 <b>Detaching from Emotional Pain</b> Handout	In section <i>What if Grounding Does not work?</i> – change reference to "Create a cassette tape..." to "Create a recording..."	Bring the language up to date.
13	p136 Ideas for Commitment	Remove "Try to remember every major Red Sox Player from the 1970s"	Too culturally specific to the US
14	p186 <b>Compassion</b> Handout 1	In section <i>Harshness may be associated with PTSD and substance abuse</i> replace reference to "jerk" with "Idiot"	We not use the term 'jerk' in the UK.
15	p187 <b>Compassion</b> Handout 1	Replace last practice example "You got a poor grade on an exam" with "You received an overdue electricity bill you can't pay."	More relevant to the client group involved in the research study.
16	p194 <b>Red and Green Flags</b> – handout 1	(1) Replace "lying" with "distorting the truth" (2) Replace "clean" with "people who do not use" *	Softer less judgemental language
17	p196 <b>Red and Green Flags</b> – handout 2	Change "increase AA to 3 times per week" - to "increase 12 step or peer support meetings to three times per week" *	Provide alternative to AA
18	p205 <b>Honesty</b> – Handout	Replace "lie" with "distorting the truth" Replace "cheating on urine testing" with "lying to a keyworker" *	Less judgemental  Not all clients will be in a service that does urine testing.
19	p272 <b>Setting Boundaries in Relationships</b> Handout 1	Final para beginning <i>Healthy boundaries can keep you safe</i>  Replace (1) "...keep you from getting AIDS" with "...help protect you from HIV, STI or getting pregnant" *	(1) Better reflects how clinicians in the UK would speak about this subject with clients

		<p>(2) replace “protect you from abusive relationships and domestic violence” with “help you avoid potential abusive people” *</p> <p>(3) Remove “You may say you will not go back to an abusive partner but then you do.” *</p>	<p>(2) Saying no can actually increase risk and danger in abusive relationships so need to be careful with this advice.</p> <p>(3) Dv practitioners in the UK would not approach this issue in this manner - as this reasons someone may return to a partner are complex and nuanced.</p>
20	<p>p274 <b>Setting Boundaries in Relationships</b> Handout 2</p>	<p><i>Para Examples: Saying No in Substance Abuse and PTSD</i> Replace (1) “Self-respect means no substances today” with “No substances today – I’m worth more” * (2) “Working as a prostitute...” with “Involvement in sex trading...” * (3) “Seeing war movies...” with “Watching violent programmes...”  (4) Section “How to Say No” Replace “I’m an alcoholic” with “I find it hard to stop” *</p>	<p>(1) less judgemental, (2) seen as a pejorative term (3) more relevant to wider client group (4) Language more akin to treatment philosophy of services</p>
21	<p>p276 <b>Setting Boundaries in Relationships</b> Handout 3</p>	<p>Section “Situations where you can learn to say yes” Replace (1) “joining a club or organisation” with “enrolling in a social activity” (2) “hotline” with helpline  <b>Examples of “saying Yes in Substance Abuse and PTSD”</b> (3) Replace “Please come with me to an AA meeting” to “please come with me to a peer support meeting” * (4) Replace “I will try and speak at an AA meeting with “I will try to speak in a peer support meeting” * In Set Goals section (5) replace “Decide to make one social call a week, or try one new meeting a week” to “try to</p>	<p>(1), (2) &amp; (5) more akin to language that would be used here <b>(3) &amp; (4) as above re AA</b> (6) Softer, less judgemental term</p>

		increase your socialising with people you feel safe around"	
		(6) In section "Role plays for saying Yes" replace "weakness" with areas of vulnerability"	
22	p279 <b>Setting Boundaries in Relationships</b> Handout 4	<b>(1) Delete "try co-dependents anonymous" *</b> <b>(2) replace USA domestic violence numbers with UK ones *</b>	<b>(1) &amp; (2) reflect the services available here in the UK</b>
23	p245 <b>Creating Meaning</b> Handout	No additional changes	
24	p342 <b>Self Nurturing</b> Handout 1	No additional changes	
25	p356 <b>Healing from Anger</b> Handout 3	<b>Delete para "Get rid of weapons until you are safe to keep them" *</b>	<b>Not relevant to the UK context</b>
26	p361 Ideas for commitment	In "option 1" Remove "of a tape"	
27	p365 <b>Life Choices Game</b>	No additional changes	

## Appendix 14: COM-B and TDF domains relevant to the intervention

TDF	What needs to happen for the target behaviour to occur?
<b>COM-B Domain: Psychological capability</b>	
<i>Knowledge</i>	Individual has understanding about PTSD symptoms and trauma in relation to substance use
	Individual has understanding of the concept of safety
	Individual has awareness of domestic violence
<i>Cognitive</i>	Cognitive functioning (i.e. right brain, mid-prefrontal cortex) no longer overwhelmed by emotionally-driven areas of the brain (i.e. left brain, amygdala)
	Re- appraisal of trauma event
	Able to identify bodily internal cues
	Able to learn coping strategies for PTSD symptoms and substance use
<i>Interpersonal skills</i>	Development of interpersonal boundaries
	Prioritization of own needs, self-care
<i>Memory and decision processes</i>	Improved concentration and ability to make decisions (severely impacted by depression/PTSD symptoms)
<i>Behavioural regulations</i>	Increased sense of self-efficacy
	Experimentation with strategies to tolerate cravings and manage PTSD symptoms
<b>COM-B Domain: Reflective motivation</b>	
<i>Social role and identity</i>	Increased positive self-identity – positive values
	Connecting with safe and non-using peers with shared interests
<i>Beliefs about capabilities</i>	Belief that substance use is an unhealthy coping mechanism and exacerbates PTSD symptoms
	Belief in ability to control PTSD symptoms and that alternative coping strategies work to address PTSD and substance use symptoms (linked to self-efficacy)
	Confidence in abilities to make required changes (linked to self-efficacy)
<i>Optimism</i>	Belief that change/recovery is possible – see an alternate future
<i>Beliefs about consequences</i>	Belief that different choices result in different outcomes

<i>Intentions</i>	Commitment to make a change or new skills/learning outside of the session
<i>Goals</i>	Understanding larger goals; staged approaches, setting achievable smaller goals, action plans to achieve these
<b>COM-B Domain: Automatic Motivation</b>	
<i>Reinforcement</i>	Experiencing how healthier strategies can manage PTSD and substance use symptoms
<i>Emotion</i>	Managing co-occurring depression and anxiety
	Reduced feelings of shame/guilt, low self-esteem
<b>COM-B Domain: Physical Opportunity</b>	
<i>Environmental context and resources</i>	Gender specific and trauma-informed practice within service delivering the intervention
	Provision of advocacy/case management, referrals and partnership working.
	Holistic provision of wrap around services to social needs e.g. IPV, sex working, community safety, housing, social services, mental health etc.
<b>COM-B Domain: Social Opportunity</b>	
<i>Social influences</i>	Provision of opportunities to connect with safe peer and social network



## Appendix 15: Using Behaviour Change Techniques to review the Seeking Safety intervention and implementation

Key: K=Knowledge; C=Cognitive; IP=Interpersonal; MAD=Memory and decision processes; BR=Behavioural regulations; SR=Social role and identity; BCap =Beliefs about capabilities; O=Optimism; BCon=Beliefs about consequences; I=Intentions; G=Goals; R=Reinforcement; E=Emotion; ER=Environmental context and resources; SI=Social Influences

BCT	Function category	How?			Capability					Motivation							Opportunity	
					Psychological					Reflective					Auto		Phys ical	Social
		Seeking Safety session format	Session topic content	Wider service response	K	C	I P	M A D	B R	S R	B C a p	O	B C o n	I	G	R	E	ER
1.1 Goal setting	Enable-ment	Individual asked to make a commitment at the end of each session (related to a coping strategy)																
1.9 Commitment		Participant asked to identify a community resource to draw on at end of each session		Keyworker support to facilitate this between sessions if needed														
1.2 Problem solving	Enable-ment	Discussion of safe behaviours to include discussion of barriers/strategies to achieving the new behaviours, triggers for old behaviours																
1.4. Action planning	Enable-ment		Red & Green Flags includes safety planning for triggers Self Nurturing & Asking for Help include planning exercise															
1.5/1.7 Review behaviour and outcome goals	Enable-ment  Education	Session check-in asks participants to recount use of safe coping skills, outcome of commitment, substance use and follow																

BCT	Function category	How?			Capability					Motivation						Opportunity			
					Psychological					Reflective						Auto		Phys ical	Social
		Seeking Safety session format	Session topic content	Wider service response	K	C	I	P	M	B	S	B	O	B	I	G	R	E	ER
2.3 Self monitoring of behaviour		through with community resource																	
2.4 Self monitoring of outcome goals	Enable-ment	Encourage use of safe coping sheet, grounding exercise to include rating before/after of stress level																	
3.2/3.3 Social support (emotional and practical)	Enable-ment	Group and facilitator support for performance of new behaviour  Participant asked to identify a community resource to draw on at end of each session.  If case management action required – to be noted by facilitators and passed onto keyworker for action.	<b>Asking for Help</b> identification of safe & supportive people <b>Honesty</b> importance of honesty in relationships <b>Setting Boundaries in Relationships</b> guidance and role play practice for developing healthy relationships	Opportunities for informal socialising and developing peer support as well as attending more formal peer support groups.  Provision of 1:1 counselling and women's process group.															
4.1 Instructions on how to perform the behaviour	Modelling	Facilitators to demonstrate the role play or coping technique																	
4.3 Re-attribution	Education		<b>Compassion</b> <b>Healing from Anger</b> <b>Creating meaning</b>	Promotion of wider socio-political constructs of gendered violence															
4.4 Behavioural experiments	Education/ Training	Use of coping sheet for participants to complete (optional) in between sessions	<b>Asking for Help</b> – approach sheet asks participants to plan who they will approach and how, and to record what they predict will happen vs what actually happens.																

BCT	Function category	How?			Capability					Motivation							Opportunity	
					Psychological					Reflective							Auto	
		Seeking Safety session format	Session topic content	Wider service response	K	C	I	M	B	S	B	O	B	I	G	R	E	ER
5.1 Information about health consequences	Education		<b>PTSD: taking back your power</b> Psycho-education on links between substance use and PTS															
5.2 Information about antecedents	Education		<b>PTSD: taking back your power</b> Psycho-education about PTS and link to trauma; often precedes substance use															
5.3 Information about social and environmental consequences	Education		<b>Safety PTSD: taking back your power</b> Psycho-education on impact of trauma and PTS on life functioning															
5.4 Monitoring of emotional consequences	Education	Use of coping sheet for participants to complete (optional) in between sessions	<b>Detaching from emotional pain</b> Grounding techniques – participants asked to rate level of negative feelings before and after practice of a technique															
5.6 Information about emotional consequences	Education		<b>PTSD: taking back your power</b> Psycho-education that substance use can exacerbate PTS symptoms															
6.1 Demonstration of the behaviour	Training	Mindfulness exercise demonstrated by the facilitator at the beginning of each session	<b>Detaching from emotional pain</b> Grounding techniques – facilitator demonstrates 10 min grounding exercise															
7.1 Prompts/Cues	Enable-ment	Participants encouraged to carry the list of coping																

BCT	Function category	How?			Capability					Motivation							Opportunity										
					Psychological					Reflective							Auto		Phys ical	Social							
		Seeking Safety session format	Session topic content	Wider service response	K	C	I	P	M	A	D	B	R	S	R	B	C	O	B	C	O	n	I	G	R	E	ER
		skills for when they are feeling overwhelmed  Provision of key ring with grounding techniques  Identification of object that participant can carry to remind of grounding																									
7.5 Remove aversive stimuli	Enable-ment			Safety risk management strategies ensure perpetrator is not accessing service.  External risk management strategies in place (e.g MARAC, IDVA)																							
8.1 Behavioural practice/rehearsal	Training	Commitment identified at end of session may be to rehearse a coping strategy in between sessions.	<b>Behavioural</b> topics have patients do a walk through stating out loud exactly what actions they would take to solve behavioural problem. <b>Interpersonal</b> topics have participants role play how they would address the problem. <b>Life Choices Game</b> is dedicated to rehearsal of number of coping skills																								
8.2 Behaviour substitution	Training	List of over 80 coping skills forms basis of the programme. Focus on all sessions is to try different coping strategies to address impacts of PTSD/trauma rather than substance use.																									
9.3 Comparative	Persuasion	Replay the scene exercise used to help																									

BCT	Function category	How?			Capability					Motivation							Opportunity													
					Psychological					Reflective							Auto		Phys ical	Social										
		Seeking Safety session format	Session topic content	Wider service response	K	C	I	P	M	A	D	B	R	S	R	B	C	a	p	O	B	C	o	n	I	G	R	E	ER	SI
imagining of future outcomes		participants identify something that went wrong and how they would do it differently																												
11.1 Pharmacological support	Enable-ment			Prescribing medication																										
11.2 Reduce negative emotions	Enabl-ement	Mindfulness exercise at the beginning of each session.  Encouragement of use of self-soothing kit	<b>PTSD: taking back your power</b> <b>Detaching from Emotional Pain</b> grounding techniques for affect regulation <b>Self-Nurturing</b> – promoting of better self care <b>Compassion</b> – rehearsal of compassionate self talk <b>Healing from Anger</b> – techniques to manage anger <b>Creating meaning</b> – identify healing meanings through cognitive restructuring	Provision of alternative holistic therapies:  Trauma informed yoga Massage Aromatherapy Art & music classes Gardening club																										
12.1 Restructuring the physical environment	Enablement/ Environmental restructuring			Provision of advocacy support for change in housing – move to safer environment																										
12.2 Restructuring the social environment	Enablement/ Environmental restructuring		<b>Red and Green flags</b> – identification of people or places that are triggers <b>Asking for help</b> – identification of safe & supportive people <b>Setting Boundaries in Relationships</b> – guidance and role play practice for developing healthy relationships	Provision of advocacy to address external safety concerns (e.g. IPV, prostitution, gang activity) .  Provision of opportunities for socialising with safe and non-using support network																										
12.3 Avoidance – reducing	Enablement		<b>Red and Green flags</b> – identification of people or places that are triggers	Provision of advocacy to address external safety																										

BCT	Function category	How?			Capability					Motivation							Opportunity												
					Psychological					Reflective							Auto		Phys ical	Social									
		Seeking Safety session format	Session topic content	Wider service response	K	C	I	P	M	A	D	B	R	S	R	B	C	a	p	O	B	C	o	n	I	G	R	E	ER
exposure to cues for the behaviour			<b>Setting Boundaries in Relationships</b> – exploring ways to say no	concerns (e.g IPV, sex-trading, gang activity)																									
12.5 Adding objects to the environment	Enablement/ Environmental restructuring			Provision of community space to socialise. Provision of breakfast and lunch																									
13.2 Framing/ Reframing	Persuasion		<b>Creating meaning</b> – identify healing meanings through cognitive restructuring. <b>Self-Nurturing</b> – promoting of better self-care <b>PTSD: Taking Back your Power</b> – understanding and normalising PTSD symptoms and substance use as coping mechanism	Non-pathologising service response to PTSD and substance use  Promotion of wider socio-political constructs of gendered violence																									
13.4 Valued self-identity	Enablement		<b>PTSD: Taking Back your Power</b> – participant asked to write down list of their strengths in face of adversity <b>Honesty</b> – importance of honesty in relationships <b>Setting Boundaries in Relationships</b> – guidance and role play practice for developing healthy relationships	Opportunities for volunteering/peer support mentor roles within the service																									
15.1 Verbal persuasion about capabilities	Persuasion		<b>Safety</b> – key message is that there is a safe coping skill that will work for you <b>PTSD: Taking Back your Power</b> – key message that healing is possible																										
15.3 Focus on past successes	Persuasion	Exploration of times when coping skill has been successfully used, praise from group and facilitators, emphasis on																											

BCT	Function category	How?			Capability					Motivation							Opportunity	
					Psychological					Reflective						Auto		Physical
		Seeking Safety session format	Session topic content	Wider service response	K	C	I	M	B	S	B	O	B	I	G	R	E	ER
		strengths and survival skills																
15.4 Self talk	Persuasion		Compassion – identifying and replacing negative self-talk Creating meaning – creating meanings that are healing															

## Appendix 16: Seeking Safety Adherence Scale

Seeking Safety Adherence Scale – page 1

6-20-03 (version 3); contact info updated 12-10-14

### SEEKING SAFETY ADHERENCE SCALE

This scale can be used for either individual or group treatment. It has three sections:

PART 1: FORMAT

*Did the clinician follow the session structure of Seeking Safety? (e.g., check-in)*

PART 2: CONTENT

*Did the clinician use the Seeking Safety content? (e.g., topics such as Honesty)*

PART 3: PROCESS

*Did the clinician use strong general clinical skills? (e.g., empathy, warmth)*

Please note:

- (1) Many items have two ratings:
  - **Adherence**, which is the idea of quantity (i.e., how much did the clinician do the Seeking Safety treatment?)
  - **Helpfulness**, which is the idea of quality (i.e., how helpful was the clinician?). This item is based both on how the clinician came across and also by how clients seemed to respond.
- (2) All items range from 0 (low) to 3 (high), with higher equal to “better”. You can use .5 ratings such as “1.5” and this is recommended to offer the most fine-tuned, useful ratings.
- (3) It is helpful to use the Score Sheet and to fill out the *Format Worksheet* on the last two pages of the Score Sheet, for all sessions.
- (4) You can mark “can’t rate” on the scoring sheet if you feel unable to rate an item (e.g., part of the tape was inaudible; the session was very short; or you did not understand the item).
- (5) **Please complete all ratings based on watching the full session, and in comparison to a very high standard: how an expert, well-trained in this treatment, would conduct it.** This means that you will generally be using the full range of the scale, as most sessions have some flaws. Please be honest about both strengths and weaknesses; giving a clinician all positive ratings does not help growth, nor does it result in the highest quality work being provided to clients. *Keep clients’ well-being as the central goal.* Note that it is unusual for a clinician, especially one new to the model, to obtain mostly 3’s.
- (6) The “not applicable” (NA) code for adherence will rarely be used as all items are part of each session except in the rare event of a life-or-death emergency, or the use of session 1a (case management). *If NA is used, list the reason on the scoring sheet in the margin.*
- (7) While listening to a session tape, take on-going notes as indicated on the Score Sheet. Use marks to identify issues that are important to raise with the clinician in supervision, e.g., + (plus sign) for strengths, and - (minus sign) for weaknesses. After listening to the entire tape, rate the items using the notes as a guide.
- (8) For each item, relevant page numbers in the manual are provided to assist supervision of the clinician. Direct the clinician to reread specific sections of the manual for all areas that are weak (e.g., 0 and 1 ratings). Also, have the clinician read other relevant works as needed (e.g., books on trauma, PTSD, substance abuse, cognitive-behavioral therapy).
- (9) This scale is copyrighted Najavits, L.M. (2003), based on earlier versions starting with Najavits L.M. & Liese, B.S. (1996). You are welcome to use this scale and score sheet for research on Seeking Safety or for clinical use within your agency or practice. **For permission to adapt the scale or score sheet for other purposes or to distribute it beyond these uses, please contact Lisa M. Najavits, Ph.D.,** Treatment Innovations, 28 Westbourne Rd., Newton Centre, MA 02459; info@seekingsafety.org (email); 617-299-1620 (telephone); or see [www.treatment-innovations.org](http://www.treatment-innovations.org) (section “assessment”). For information about the Seeking Safety treatment, please see [www.seekingsafety.org](http://www.seekingsafety.org).

Najavits, LM (2003). *Seeking Safety Adherence Scale*. Unpublished manuscript, McLean Hospital, Belmont, MA. See page 1 for information on adapting and distributing this scale.



**Part 1: Structure**

\*\*\*\*\*For PART 1 please fill out the “worksheet” on the scoresheet as the basis for ratings\*\*\*\*\*

**(1) CHECK-IN**

The goal of the check-in is a brief update (up to 5 minutes per client), using the five check-in questions. The clinician makes only brief comments (e.g., praise or concern), and notes material to return to later in the session. *In group, clinician promotes each client’s “space” without cross-talk from other group members.*

© **For supervision.** Pages in the manual to assist clinician: 33-35; 54-55.

Rating	ADHERENCE (quantity)	Rating	HELPFULNESS (quality)
<b>NA</b>	Check-in not required (e.g., case management session, or life/death emergency).	<b>NA</b>	Can't rate because appropriately not done in session
<b>0</b> <b>Not done</b>	Did not conduct check-in, but should have	<b>0</b> <b>Harmful</b>	Check-in punitive (e.g., “You were bad to use substances”), hurtful, or neglectful (e.g., ignores client’s suicidal feelings)
<b>1</b> <b>Done</b> <b>A little</b>	Minimally complete (e.g., made attempt at check-in, but clearly lacking in some components or time limits; or intervened far too much or too little)	<b>1</b> <b>Ineffective</b>	Uninvolved, listened but did not appear supportive or helpful; cut clients off abruptly rather than redirecting in a kind way
<b>2</b> <b>Done</b> <b>A lot</b>	Mostly complete; did check-in with only minor flaws	<b>2</b> <b>Somewhat helpful</b>	Attentive and basically good, but some flaws (e.g., overly rushed)
<b>3</b> <b>Done</b> <b>thoroughly</b>	100% complete: all components of check-in completed within time limits and with optimal level of interaction from clinician	<b>3</b> <b>Extremely helpful</b>	Conveyed sincere interest and support in clients’ progress; clients appeared to feel heard and cared for

**(2) QUOTATION**

Conducted after check-in; no more than two minutes on quotation; have client read quote out loud; ask “What is the main point?” and allow client to answer; clarify if patient does not understand; link to session topic.

© **For supervision.** Pages in the manual to assist clinician: 35, 54-55.

Rating	ADHERENCE (quantity)	Rating	HELPFULNESS (quality)
<b>NA</b>	Quotation not applicable (e.g., more than one session on same topic).	<b>NA</b>	Can't rate because appropriately not done in session
<b>0</b> <b>Not done</b>	Quotation not done, but should have been done	<b>0</b> <b>Harmful</b>	Client made to feel stupid for not understanding quotation; or a harmful message conveyed about the quotation
<b>1</b> <b>Done</b> <b>A little</b>	Too much or too little time on quotation, done at wrong time, or clinician alone identifying main point	<b>1</b> <b>Ineffective</b>	Went through the motions, misunderstood the quotation, or told client what to think without letting client explore it

<b>2 Done A lot</b>	Quotation mostly conducted as planned, with only minor flaws (e.g., asked “How do you like the quote?”)	<b>2 Somewhat helpful</b>	Used the quotation in a way that appeared somewhat beneficial
<b>3 Done thoroughly</b>	Quotation fully addressed as specified in the manual	<b>3 Extremely helpful</b>	Able to use the quotation to fullest advantage to help client feel inspired and engaged in the session

### (3) HANDOUTS

Each topic has a set of handouts. After the quotation (see item #2 above), the clinician encourages clients to take a few minutes to look through the handouts, and then asks an open-ended question (e.g., “Any reactions?”) to start the discussion. The clinician may want to summarize the handouts briefly if clients have trouble reading, or in a group, clients may take turns reading small sections out loud. But in general, it’s best to allow clients to explore the handouts rather than over-controlling the process (e.g., reading every line, “lecturing” at clients, going through each page in order).

④ **For supervision.** Pages in the manual to assist clinician: 36-40; 54-55.

	<b>ADHERENCE (quantity)</b>	Rating	<b>HELPFULNESS (quality)</b>
<b>NA</b>	Handout not required (e.g., case management session, or life/death emergency).	<b>NA</b>	Cannot be rated because appropriately not done in session
<b>0 Not done</b>	Omitted handouts entirely, or gave them out but then did not work with them	<b>0 Harmful</b>	Used handouts in way that made clients feel ignored, judged, or unimportant (e.g., just had clients read handouts out loud with no attempt to process it or relate it to their lives)
<b>1 Done A little</b>	Minimal attention to handouts (little time spent on them)	<b>1 Ineffective</b>	Superficial attempt to use handouts, going through the motions (e.g., “We need to get through this”), or disorganized and unclear
<b>2 Done A lot</b>	Reviewed handouts with considerable thoroughness and only minor flaws (e.g., went off-topic briefly)	<b>2 Somewhat helpful</b>	Tried to help clients understand and benefit from the handout (e.g., asked for clients’ own examples, clarified terms); but overall effect was less than excellent
<b>3 Done thoroughly</b>	Handouts used as described in manual; and spent most of the session on them (e.g., reading, discussion, rehearsal).	<b>3 Extremely helpful</b>	Used the handouts in outstanding and highly therapeutic manner; did not appear “bookish” but rather deeply moved clients toward change

### (4) CHECK-OUT

The goal of the check-out is to close out the session using three questions. Note that the commitment can be any specific homework; it does not have to relate to the session topic.

④ **For supervision.** Pages in the manual to assist clinician: 41-44, 54-55.

Rating	<b>ADHERENCE (quantity)</b>	Rating	<b>HELPFULNESS (quality)</b>
<b>NA</b>	Check-out not required (e.g., case management session, or life/death emergency).	<b>NA</b>	Can’t rate because appropriately not done in session

<b>0</b> <b>Not done</b>	Did not conduct check-out at all, but should have	<b>0</b> <b>Harmful</b>	Check-out negative (e.g., angry at client's critical feedback about session) or neglectful (e.g., ignores suicidal feelings)
<b>1</b> <b>Done A little</b>	Minimal (e.g., made attempt, but clearly lacking in some components, intervened too much, or time was too long or too short)	<b>1</b> <b>Ineffective</b>	Uninvolved or unsupportive; e.g., unable to help client identify a new commitment
<b>2</b> <b>Done A lot</b>	Mostly complete (e.g., did check-out solidly for each client, but minor problems)	<b>2</b> <b>Somewhat helpful</b>	Attentive and basically good, but somewhat lacking (e.g., talking too much)
<b>3</b> <b>Done thoroughly</b>	100% complete: all components of check-out completed within time limits and with optimal level of interaction from clinician	<b>3</b> <b>Extremely helpful</b>	Conveyed sincere interest and support in clients' progress, provided optimal level of guidance; clients appeared to feel heard and cared for; helped clients identify useful commitments and community resources

### Part 2: Content

#### (5) FOCUS ON TRAUMA/PTSD

Every session, the clinician should address trauma/PTSD in some way. This may include bringing up trauma-relevant examples, helping the client work on trauma symptoms; helping the client understand the connection between trauma and substance abuse, etc.

© **For supervision.** Pages in the manual to assist clinician: 5-8, 40 (top of page), 46-48, 110-116.

Rating	<b>ADHERENCE (quantity)</b>	Rating	<b>HELPFULNESS (quality)</b>
<b>NA</b>	Appropriately not done (e.g., case management session or life/death emergency)	<b>NA</b>	Can't rate because not done in session
<b>0</b> <b>Not done</b>	No mention of trauma/PTSD.	<b>0</b> <b>Harmful</b>	Dealt with trauma/PTSD in harsh, disrespectful, angry, controlling, or judgmental way, or, gave wrong information (e.g., "No one recovers from PTSD")
<b>1</b> <b>Done A little</b>	Minimal amount of time spent on trauma/PTSD	<b>1</b> <b>Ineffective</b>	Ignored obvious opportunities to focus on trauma/PTSD, or attended to them in ways that were overly superficial (e.g., "Just learn to forgive")
<b>2</b> <b>Done A lot</b>	A fair amount of time in session spent on trauma/PTSD	<b>2</b> <b>Somewhat helpful</b>	Trauma/PTSD interventions were somewhat useful, e.g., conveyed knowledge, or provided simple but helpful interventions ("How about reading a book on PTSD?")
<b>3</b> <b>Done thoroughly</b>	Considerable amount of time in session was devoted to trauma/PTSD, in ways specified in the manual	<b>3</b> <b>Extremely helpful</b>	Sophisticated, state-of-the art effort to intervene on trauma/PTSD (e.g., important new learning, worked on clients' examples in very meaningful way, or helped to decrease symptoms)

Najavits, LM (2003). *Seeking Safety Adherence Scale*. Unpublished manuscript, McLean Hospital, Belmont, MA. See page 1 for information on adapting and distributing this scale.

**(6) FOCUS ON SUBSTANCE ABUSE**

Every session, the clinician should address substance abuse in some way. This may include exploring reasons why client used substances, identifying ways to prevent substance use, linking trauma/PTSD with substance use, etc.

© **For supervision.** Pages in the manual to assist clinician: 6-8, 14, 44, 49, 51, 137-163, 360.

Rating	<b>ADHERENCE (quantity)</b>	Rating	<b>HELPFULNESS (quality)</b>
<b>NA</b>	Appropriately not done (e.g., case management session or life/death emergency)	<b>NA</b>	Can't rate because appropriately not done in session
<b>0 Not done</b>	No mention of substance abuse	<b>0 Harmful</b>	Dealt with substance abuse in harsh, disrespectful, angry, controlling, or judgmental way, or, gave wrong information
<b>1 Done A little</b>	Minimal amount of time spent on substance abuse	<b>1 Ineffective</b>	Ignored obvious opportunities to focus on substance abuse, or attended to it in superficial way that appeared to have little impact
<b>2 Done A lot</b>	A fair amount of time in session spent on substance abuse	<b>2 Somewhat helpful</b>	Substance abuse interventions were somewhat useful, e.g., conveyed useful knowledge, or provided simple but helpful interventions ("How about going to AA?")
<b>3 Done thoroughly</b>	Considerable amount of time in session was devoted to substance abuse, in ways specified in the manual	<b>3 Extremely helpful</b>	Sophisticated, state-of-the art effort to intervene on substance abuse (e.g., important new learning, worked on clients' examples in very meaningful way, or helped to develop contract and/or strategies to prevent future use)

**(7) SAFE COPING**

The goal is to help clients learn to cope in safe ways, no matter what happens. There are many ways the clinician can work on safe coping, including the session topic (each of which is a safe coping skill), use of the *List of Safe Coping Skills*, and use of the *Safe Coping Sheet*. Even if the session goes off topic at times, it should still recognizably attend to safe coping skills (which may be cognitive, behavioral, interpersonal, or a mix of these).

© **For supervision.** Pages in the manual to assist clinician: 5-6, 40-41, 50-51, 58, 94-109.

Rating	<b>ADHERENCE (quantity)</b>	Rating	<b>HELPFULNESS (quality)</b>
<b>NA</b>	Appropriately not done (e.g., life/death emergency).	<b>NA</b>	Can't rate because not done in session
<b>0 Not done</b>	No attention to safe coping	<b>0 Harmful</b>	Clinician harsh or coercive (e.g., "You have to do it my way"), gave poor information (e.g., "Rethinking means thinking positively"); was demeaning (e.g., "If you don't set a boundary, you're a masochist"); or used coping inappropriately (e.g., told client to do grounding when she does not have money for food)

<b>1</b> <b>Done</b> <b>A little</b>	Minimal amount of time spent on safe coping	<b>1</b> <b>Ineffective</b>	Vague or overly abstract; superficial advice rather than therapeutic processing; unable to get clients to explore or change their coping; “lite” interventions (“Just do it!”)
<b>2</b> <b>Done</b> <b>A lot</b>	A fair amount of time in session spent on safe coping. <i>Use this rating if clinician strayed from the session topic, but still did a lot of work on safe coping.</i>	<b>2</b> <b>Somewhat helpful</b>	Reasonable work though did not go far enough (e.g., asked client to go to an AA meeting, but did not explore possible obstacles); conveyed some useful help but not deep enough, or not fully convincing
<b>3</b> <b>Done</b> <b>thoroughly</b>	Considerable amount of time in session was devoted to safe coping. <i>For this rating, clinician needs to have spent most of the session on the session topic.</i>	<b>3</b> <b>Extremely helpful</b>	Masterfully helped clients develop and implement new safe coping to promote recovery; convincing, realistic, and specific (e.g., did successful rethinking exercise or role-play); worked on emotional obstacles to change; helped clients move to a higher level; was respectful and insightful.

#### (8) TOPIC DISCUSSION AND REHEARSAL

The clinician promotes clients’ growth by encouraging discussion and rehearsal of the session topic (e.g., Honesty) in relation to the clients’ current life problems. Rehearsal refers to active techniques such as role play, think-aloud, the *Safe Coping Sheet*, making a tape, replaying the scene, experiential exercise, question/answer, etc. The clinician does not need to review everything on handout; it is fine to be selective and adapt to the clients’ needs, but whatever is covered should be done in-depth.

④ **For supervision.** Pages in the manual to assist clinician: 36-39, 40, 58, and “Session Content” in each topic’s therapist guide.

Rating	<b>ADHERENCE (quantity)</b>	Rating	<b>HELPFULNESS (quality)</b>
<b>NA</b>	Appropriately not done (e.g., life/death emergency).	<b>NA</b>	Can’t rate because appropriately not done in session
<b>0</b> <b>Not done</b>	No discussion or rehearsal (i.e., clinician totally off-topic)	<b>0</b> <b>Harmful</b>	No new learning (e.g., clinician chats about trivial issues, is not focused on providing growth experience for client, or covers topic in way that makes client feel hurt, diminished, or put down)
<b>1</b> <b>Done</b> <b>A little</b>	Minimal amount of discussion and rehearsal (e.g., not enough time or effort to truly accomplish learning of topic)	<b>1</b> <b>Ineffective</b>	Superficial attention to the topic; jumping all over to too many different things; or clinician unable to really help the client understand
<b>2</b> <b>Done</b> <b>A lot</b>	Solid discussion and rehearsal (e.g., did both somewhat, or did one very well)	<b>2</b> <b>Somewhat helpful</b>	Some good work on the topic, some new learning, but a sense that it didn’t go as far as might have
<b>3</b> <b>Done</b> <b>thoroughly</b>	Excellent attention to both discussion and rehearsal (only rate “3” if <u>both</u> present)	<b>3</b> <b>Extremely helpful</b>	Expert intervention that appeared to have genuine impact on client; a sense of new understanding and important change

Najavits, LM (2003). *Seeking Safety Adherence Scale*. Unpublished manuscript, McLean Hospital, Belmont, MA. See page 1 for information on adapting and distributing this scale.

**(9) FOCUS ON CURRENT, SPECIFIC, IMPORTANT CLIENT PROBLEMS**

While many client issues could be worked on, the goal is to select ones that are (a) described during check-in to be recent unsafe behavior (e.g., substance use or self-harm); (b) current (e.g., problems in the past week or two or upcoming week or two rather than lengthy discussion of the far past or distant future); (c) specific (e.g., solvable problems); and (d) ones that clients want to work on. If clients bring up abstract goals such as “wanting to feel better”, the clinician’s role is to help identify how to work on these in specific ways in the present.

© **For supervision.** Pages in the manual to assist clinician: 13, 37-39, and “Ways to Relate the Material to Patients’ Lives” in each topic’s therapist guide.

Rating	<b>ADHERENCE (quantity)</b>	Rating	<b>HELPPFULNESS (quality)</b>
<b>NA</b>	Appropriately not done	<b>NA</b>	Can’t rate because not done in session
<b>0</b> <b>Not done</b>	Clinician never addressed current, specific, important client problems	<b>0</b> <b>Harmful</b>	Avoided or ignore major issues (e.g., current domestic violence goes unaddressed); or clinician talked most of the time (“lecturing”) and did not allow space for clients to address their issues
<b>1</b> <b>Done A little</b>	Some amount of focus on current, specific, important client problems	<b>1</b> <b>Ineffective</b>	The clinician selected trivial concerns; too “bookish” (session felt like school rather than therapy); or session unfocused, aimless, or rambling.
<b>2</b> <b>Done A lot</b>	Moderate amount of focus on current, specific, important client problems	<b>2</b> <b>Somewhat helpful</b>	Focused on relevant problems, but may have gotten bogged down (e.g., an abstract discussion)
<b>3</b> <b>Done thoroughly</b>	High amount of focus on current, specific, important client problems	<b>3</b> <b>Extremely helpful</b>	Used time extremely effectively by guiding conversation to specific client concerns, redirecting when needed; good pacing; selected “hot” examples that tapped prominent issues; specific rather than vague or abstract.

**(10) BALANCE OF SUPPORT AND ACCOUNTABILITY**

The clinician offers genuine support, praise, and positive feedback, while also guiding clients to take greater responsibility for their actions by providing constructive critical feedback, appropriate confrontation, limit-setting, and motivating clients to “do the work” in session.

© **For supervision.** Pages in the manual to assist clinician: 11, 30-31.

Rating	<b>ADHERENCE (quantity)</b>	Rating	<b>HELPPFULNESS (quality)</b>
<b>NA</b>	Appropriately not done	<b>NA</b>	Can’t rate because not done in session
<b>0</b> <b>Not done</b>	No use of support or accountability	<b>0</b> <b>Harmful</b>	Destructive accountability (e.g., set limits in abusive way, gave harsh feedback that appeared to induce shame, guilt, despair, or hopelessness); and/or no support
<b>1</b> <b>Done A little</b>	Minimal amount of support and accountability (or just used one and not the other)	<b>1</b> <b>Ineffective</b>	Support felt superficial or ingenuine; accountability was absent or poorly done (e.g., clinician “walked over” by clients, appeared victimized or afraid, unable to set appropriate limits or give critical feedback; allowed client to get away with inappropriate behavior in the session; or did all the work, not requiring client effort).

Najavits, LM (2003). *Seeking Safety Adherence Scale*. Unpublished manuscript, McLean Hospital, Belmont, MA. See page 1 for information on adapting and distributing this scale.

<b>2 Done A lot</b>	Fair amount of support and accountability, and reasonably balanced	<b>2 Somewhat helpful</b>	Support felt validating, and clients were held to reasonably high standards; but with some flaws (e.g., gave critical feedback indirectly)
<b>3 Done thoroughly</b>	High amounts of support and accountability, in balanced fashion	<b>3 Extremely helpful</b>	An outstanding job of genuine support while also encouraging clients to do their best within their developmental level; did not give up on any client; gave accurate critical feedback in caring way

**(11) CASE MANAGEMENT**

The case management aspect of the treatment is designed to provide guidance and referrals to help clients locate additional help (e.g., for domestic violence, housing, medication, self-help groups).

© **For supervision.** Pages in the manual to assist clinician: 10-11, 65-93.

Rating	<b>ADHERENCE (quantity)</b>	Rating	<b>HELPFULNESS (quality)</b>
<b>NA</b>	Appropriately not done (i.e., no case management issues necessary to address)	<b>NA</b>	Can't rate because not done in session
<b>0 Not done</b>	Case management issues not addressed despite need to address them	<b>0 Harmful</b>	Addressed case management issues in harmful ways (e.g., forcing a treatment client does not want; minimizing valid concerns) or giving destructive advice (e.g., "Stay with your clinician even if it feels unhelpful")
<b>1 Done A little</b>	Addressed case management issues a little but less than appeared necessary	<b>1 Ineffective</b>	Attempts to address case management issues were unlikely to result in real progress (e.g., gave referral without checking whether client could pay for it)
<b>2 Done A lot</b>	Addressed most of case management issues that appeared necessary	<b>2 Somewhat helpful</b>	Reasonable success in addressing case management needs, but with some limitations (e.g., addressed practical issues but not emotional obstacles)
<b>3 Done thoroughly</b>	Fully addressed case management issues that appeared necessary. <i>Can include setting up time for individual case management session</i>	<b>3 Extremely helpful</b>	Conducted case management in a way that therapeutically addressed both the practical needs of clients (appropriate referrals) and also emotional obstacles (e.g., fear of new treaters, lack of initiative)

**(12) ABSENCE OF GRAPHIC DETAILS OF TRAUMA OR SUBSTANCE USE**

The clinician focuses on trauma and substance abuse without allowing clients to go into graphic detail, which could become unsafe. Clinician redirects client if necessary, but in kind, validating way. However, clients can briefly mention nature of trauma (e.g., "I was sexually abused as a child") and relevant details of substance abuse (e.g., "I had six drinks at a bar").

© **For supervision.** Pages in the manual to assist clinician: 8, 14-15, 46-48, 113-114.

Rating	<b>ADHERENCE (quantity)</b>	Rating	<b>HELPFULNESS (quality)</b>
<b>NA</b>	Appropriately not done	<b>NA</b>	Can't rate because not done in session

<b>0 Not done</b>	Considerable graphic details of trauma or substance abuse details (e.g., “war stories”)	<b>0 Harmful</b>	“Digs” for details, or allows client to trigger self or others through graphic, lengthy details of trauma or substance use; some harmful reaction observed (e.g., client dissociates, leaves room, or complains)
<b>1 Done A little</b>	Fair amounts of graphic trauma or substance abuse details	<b>1 Ineffective</b>	Tries to keep trauma or substance use details out of session but unable to do so (e.g., asks client to stop, but client keeps going)
<b>2 Done A lot</b>	Minimal amounts of graphic trauma or substance abuse details	<b>2 Somewhat helpful</b>	Makes reasonable attempt to keep trauma or substance use details out of session but does not go far enough (e.g., client cut off in abrupt way)
<b>3 Done thoroughly</b>	No discussion of graphic trauma or substance abuse details; clinician able to redirect if needed	<b>3 Extremely helpful</b>	Protects safe atmosphere in room by redirecting clients away from graphic details of trauma or substance use; does so in caring, validating way (e.g., explains rationale) <i>[or: rate 3 if gave “3” on adherence]</i>

### Part 3: Process

#### (13) WARMTH AND CARING

Clinician offers genuine compassion, kindness, praise, and high level of care.

© **For supervision.** Pages in the manual to assist clinician: 11, 30-31, and the section “Countertransference” in each topic’s therapist guide.

Rating	ADHERENCE/HELPFULNESS
<b>NA</b>	Use “NA” if for any reason it is not applicable to rate this item
<b>0 Not done/ Harmful</b>	Indifferent, cold (e.g., ignores client crying); hurtful (e.g., mean, shaming, or blaming); total absence of praise or praise insincere, sarcastic, or excessive; and/or overwhelmed by own emotions (e.g., very frustrated and angry)
<b>1 Done a little/ Ineffective</b>	Too little warmth; clinician’s own emotions or needs seem to get in the way of “being there” for client emotionally; praise, if done, is superficial (e.g., says the right words but tone is not genuine)
<b>2 Done a lot/ Somewhat helpful</b>	Quite warm and caring but some flaws (e.g., less than optimal amount of praise)
<b>3 Done thoroughly/ Extremely helpful</b>	The clinician did an outstanding job of conveying heartfelt warmth and caring, and avoided all traces of hostility or blame. Exemplary use of praise (specific, sincere) that appeared to motivate clients

#### (14) DEPTH

Depth refers to a sense that the work is highly important, meaningful, and taps new levels of awareness for the client.

© **For supervision.** Pages in the manual to assist clinician: 29-32.

Najavits, LM (2003). *Seeking Safety Adherence Scale*. Unpublished manuscript, McLean Hospital, Belmont, MA. See page 1 for information on adapting and distributing this scale.



Rating	ADHERENCE/HELPFULNESS
<b>NA</b>	Use “NA” if for any reason it is not applicable to rate this item
<b>0 Not done/ Harmful</b>	Depth absent (e.g., session focused only on trivial issues), missed major opportunities, and/or aimed for depth but did so in disrespectful or harmful way (e.g., “You have to write a letter to your abuser forgiving him”)
<b>1 Done a little/ Ineffective</b>	Mostly superficial, with little attempt or ability to get to meaningful client issues
<b>2 Done a lot/ Somewhat helpful</b>	Quite able to attain depth, but with some flaws (e.g., chatting about the weather for some part of the session)
<b>3 Done thoroughly/ Extremely helpful</b>	Ability to work with clients at a deeply meaningful level, understanding their experience in a way that conveys genuine, intelligent perception of clients (e.g., beyond clients’ own understanding of self); able to resonate with their way of looking at the world yet see beyond it as well.

#### (15) MANAGEMENT OF CRISES AND EXTREME EMOTION

The goal is to soothe and contain clients who become overly upset (using grounding and empathy), address important crises (e.g., client has been assaulted and needs medical care), solve crises in professional yet kind ways, and, in group treatment, to do so while preventing other clients’ from becoming upset.

© **For supervision.** Pages in the manual to assist clinician: 30, 49-51, 125-136.

Rating	ADHERENCE/HELPFULNESS
<b>NA</b>	No crises to manage (e.g., client cutting arm in session); no extreme affects to manage (e.g., rage, dissociation, crying, panic attack).
<b>0 Not done/ Harmful</b>	Did not address crisis or extreme affect (e.g., ignored it); or addressed in destructive way (e.g., power struggles); clients deteriorated or increasingly upset, and negative feelings were increased rather than decreased
<b>1 Done a little/ Ineffective</b>	Attempted resolution of crisis or extreme affect, but unsuccessful (e.g., was overly anxious, could not get client to safe place)
<b>2 Done a lot/ Somewhat helpful</b>	Attentive to clients’ extreme affects or crises in a way that allowed diffusion, calming, and adequate plan; able to maintain reasonable professional demeanor, but with some deficiency (e.g., took too long or dealt with one client to exclusion of other clients’ needs)
<b>3 Done thoroughly/ Extremely helpful</b>	Excellent job of attending sensitively and effectively to extreme affects and crises; quick diffusion, calming, and helpful resolution (e.g., did grounding and then moved on to rest of session); made appropriate referrals if needed (e.g., to inpatient level of care); clients may have learned important lessons and become closer; clinician able to manage difficult situation

#### (16) POWER DYNAMICS

In managing power dynamics, the goal is for the clinician to both help empower clients yet also to take charge by leading as needed, within a safe and empowering therapeutic atmosphere. The clinician is also aware of the unconscious reenactments that can occur with clients (e.g., replaying roles of victim, perpetrator, bystander, or rescuer), and is aware of anger and handles it effectively.

Najavits, LM (2003). *Seeking Safety Adherence Scale*. Unpublished manuscript, McLean Hospital, Belmont, MA. See page 1 for information on adapting and distributing this scale.

© **For supervision.** Pages in the manual to assist clinician: 11, 29-32, and see “Countertransference” in each topic’s therapist guide.

Rating	ADHERENCE/HELPFULNESS
<b>NA</b>	Use “NA” if for any reason it is not applicable to rate this item
<b>0 Not done/ Harmful</b>	Mismanaged power dynamics in way that created lack of safety: e.g., was abusive, attacking, coercive, allowed clients to trigger each other, engaged in power struggles, allowed clients to scapegoat each other, or conveyed extreme negative countertransference reactions
<b>1 Done a little/ Ineffective</b>	Attempts to manage power dynamics were ineffective. Clinician was either over-controlling or appeared overly weak (e.g., “victimized” by clients; inconsistent in way that clients may have felt unsure of how to act; or allowing clients to talk at great length without focus). Or, clinician seemed unable to “own” important negative feelings in the room, by either self or clients (anger, frustration, anxiety). In group treatment, overly addressing needs of one group member at expense of others; allowed clients to interrupt each other
<b>2 Done a lot/ Somewhat helpful</b>	A reasonably good job of managing power dynamics, with quite safe atmosphere. In group treatment, largely protected group members from each other, largely maintained balance of own authority and empowerment of clients. No obvious major negative countertransference.
<b>3 Done thoroughly/ Extremely helpful</b>	Excellent job of managing power dynamics. Created safe atmosphere; allowed clients to talk openly, sought to empower them while also maintaining own authority; promoted an egalitarian mood that was respectful of all. In group treatment, fully protected clients from each other; good balance of individual versus group needs (e.g., sharing time, taking turns); no scapegoating; group functioned “as a team”.

#### (17) LISTENING

Follows “80/20” rule (client talks approximately 80% of session, with clinician talking only about 20%). Also, clinician appears to accurately hear clients’ intended messages, and focuses on client rather than on own issues (e.g., self-disclosure does not occur unless client initiates question).

© **For supervision.** Pages in the manual to assist clinician: 30, 32, 34-35.

Rating	ADHERENCE/HELPFULNESS
<b>NA</b>	Use “NA” if for any reason it is not applicable to rate this item
<b>0 Not done/ Harmful</b>	Talking way too much or too little; did not hear clients; imposed own understanding incorrectly; important messages were missed; talked over or interrupted client; told client what to think rather than listening; distorted the meaning in destructive way; became defensive at clients’ criticism; talked about self and own needs
<b>1 Done a little/ Ineffective</b>	Talked more than client during session; “lectured” or overly controlled the session flow; interrupted client; overly concrete (e.g., not hearing emotions underneath); did self-disclosure that took focus off of client
<b>2 Done a lot/ Somewhat helpful</b>	A reasonable amount of listening; hearing clients accurately and sensitively, but with some flaws (e.g., client needed to correct clinician repeatedly before she got it, or clinician talked more than 25% of session)
<b>3 Done thoroughly/ Extremely helpful</b>	Kept “80/20 rule”; excellent job of hearing clients sensitively (“listening with the third ear”) to both verbal and non-verbal messages; able to listen to clients’ critical feedback without defensiveness; clients may have given strong indications that they felt understood (e.g., “Exactly!”, “That’s just what I meant”)

Najavits, LM (2003). *Seeking Safety Adherence Scale*. Unpublished manuscript, McLean Hospital, Belmont, MA. See page 1 for information on adapting and distributing this scale.

**(18) LEVEL OF ENGAGEMENT**

This item addresses the clinician's degree of involvement in the work, which may appear in terms of effort level; sense of the clinician being present as a human being; and use of engaging language, humor, examples, or other ways of connecting with the client.

© **For supervision.** Pages in the manual to assist clinician: 11, 12, 13, 75.

Rating	ADHERENCE/HELPFULNESS
<b>NA</b>	Use "NA" if for any reason it is not applicable to rate this item
<b>0</b> <b>Not done/ Harmful</b>	Uninvolved, bored, "robotic," predictable, obvious, unenthusiastic; resembled a bump on a log; too passive or appeared lazy to a degree that neglected clients' needs; or appeared unwilling or unmotivated to make necessary efforts to help (e.g., client asks for referral and clinician doesn't bother giving one); or ended session early
<b>1</b> <b>Done a little/ Ineffective</b>	No bells or whistles; bland, uninspired (e.g., may have done everything "by the book"; no obvious spark, interest, or excitement in clinician demeanor; perhaps a feeling of too much quiet or deadness in room, but nothing destructive going on; rater may have needed a cup of coffee to get through the tape; somewhat passive, low in effort, didn't extend self to try to really make it work)
<b>2</b> <b>Done a lot/ Somewhat helpful</b>	Applied solid effort and showed moderate desire to help clients but with some flaws (e.g., tells client will give a referral and then doesn't follow through); style was reasonably engaging, enthusiastic, interesting; conveyed a human, engaging side with some success; but could have been better
<b>3</b> <b>Done thoroughly/ Extremely helpful</b>	Worked with exemplary effort, persistence, motivation; modeled how to strive for results; active attempts to help in any way possible within professional bounds; style was highly engaging (e.g., personable, enthusiastic, colorful, charming, good use of own affect); able to draw clients in, motivate

**(19) ABSENCE OF INTERVENTIONS THAT CONFLICT WITH THE MANUAL**

This item addresses whether the clinician stayed within the treatment model, and used interventions that were congruent with it. Examples of interventions *not* congruent with the model would be intensive interpersonal processing (e.g., exploration of transference), exposure therapy (processing of graphic trauma details), and psychoanalytic therapy (e.g., unstructured session focusing on free associations). This item is rated for adherence only.

© **For supervision.** Pages in the manual to assist clinician: 14-15, 19-21.

Rating	ADHERENCE
<b>NA</b>	Use "NA" if for any reason it is not applicable to rate this item
<b>0</b> <b>Not done</b>	Considerable amount of interventions from other modalities that conflict with the manual (e.g., long silences; extensive discussion of childhood; exposure therapy methods such as detailed exploration of trauma history; passive clinician; interpretations of negative motives that clients have not articulated themselves, e.g., "You don't really want to get better")
<b>1</b> <b>Done a little</b>	Fair amount of interventions from other modalities that conflict with the manual (e.g., sounded largely like an interpersonal process session)
<b>2</b> <b>Done a lot</b>	Minimal amount of interventions from other modalities that conflict with the manual
<b>3</b> <b>Done thoroughly</b>	No use of interventions from other modalities that conflict with the manual

Najavits, LM (2003). *Seeking Safety Adherence Scale*. Unpublished manuscript, McLean Hospital, Belmont, MA. See page 1 for information on adapting and distributing this scale.

**(20) BUILDING GROUP COHESION (RATE FOR GROUP THERAPY ONLY)**

This item addresses whether, for group therapy, clinician helped create a bond between group members.

⑦ **For supervision.** Pages in the manual to assist clinician: 32, 34, 35, 46.

Rating	ADHERENCE/HELPFULNESS
<b>NA</b>	Not a group therapy session.
<b>0</b> <b>Not done/ Harmful</b>	Poor performance. Ignored the group (e.g., focused solely on one group member to exclusion of all others); or, allowed group to run wild in way that prevented cohesion (e.g., separate conversations going on at same time)
<b>1</b> <b>Done a little/ Ineffective</b>	Some attempt to help group relate to each other, but ineffective or insufficient such that group cohesion suffered (e.g., allowed one member to take up too much time, or conducted group in a way that clients rarely talked to each other)
<b>2</b> <b>Done a lot/ Somewhat helpful</b>	Clear evidence of some group cohesion (e.g., clients responding to each other, mutual support, etc.), and/or clinician clearly making efforts to build such rapport (e.g., encouraging comments, asking questions of group as a whole)
<b>3</b> <b>Done thoroughly/ Extremely helpful</b>	Outstanding group bonding (e.g., clinician involving all members, a spirit of camaraderie, group members sharing time and attention in balanced way, a feeling of a group rather than just separate clients)

**(21) OVERALL PERFORMANCE**

Create a global rating, across all items.

Rating	ADHERENCE/HELPFULNESS
<b>NA</b>	Use "NA" if for any reason it is not applicable to rate this item
<b>0</b> <b>Not done/ Harmful</b>	Poor performance. Does not demonstrate a grasp of the treatment model; major flaws in use of the treatment format, content, or process to detriment of clients; or stuck slavishly to manual in a way that lost the spirit of the work
<b>1</b> <b>Done a little/ Ineffective</b>	Fair performance. Demonstrates some basic skills but does not use the treatment model consistently or with effectiveness. Needs to improve format, content, process, timing, and/or tactfulness of interventions.
<b>2</b> <b>Done a lot/ Somewhat helpful</b>	Good performance. Has learned the treatment well and applies it comfortably. Is skillful in the application of techniques in the context of strong process skills. However, some areas that could still use improvement.
<b>3</b> <b>Done thoroughly/ Extremely helpful</b>	Excellent performance. Evidenced outstanding knowledge of the treatment with no obvious deficiencies; appeared at ease, flexible, and extremely sensitive; "state of the art"; able to use the manual as a resource without being overrun by it

## Appendix 17: Outline of Seeking Safety training provided to the group facilitators

<b>DVD One: Background, treatment, outcomes, implementation issues</b>	<b>Discussion points</b>
Background	
Post-traumatic stress disorder	How DSM-5 definition differs to that of DSM-4
Treatment options	
Importance of trauma informed care	
Overview of past focused interventions, e.g. exposure	
Overview of Seeking Safety/treatment philosophy, outcome studies	
Suggestions for using the hand-outs	<p>Safe Coping Skills – sheet (always have on hand at each session) - to refer back to it in each session, ask them what may work if they are struggling for an answer).</p> <p>Prioritise any unsafe behaviour reported at check-in. Ask clients what strikes them – what would they like to focus on.</p>
Structured format – reasons why	
Check-in and check out process	Give copy of check-in sheet, refer to IHR slide 25/26
Quotation	Question to accompany this should be what is the main point rather than what do you think
Topic and discussion	Give session outlines
<p>Discussing and THEN rehearsing</p> <p>Interpersonal = role play</p> <p>Cognitive = Think aloud e.g. “what does it sound like in your mind when you use harsh self-talk? Try reframing it out loud with compassionate talk.”</p> <p>Behavioural = walk through “Do you have the name, childcare, does someone need to go with you”</p> <p>Balance client issues with coping skill – connect the two (have coping sheet handy)</p> <p>What did you say to yourself before you were using? (Cognitive topic that week) Who did you reach out to before our after? (Behavioural topic that week)</p> <p>“How did you try and cope with that situation?” What methods did they try, what worked, what didn’t work.</p>	
Homework	Emphasis on practicing skills outside of sessions
Clinician self care and vicarious trauma	Discuss process for clinical supervision
Avoiding discussion of trauma details	<p>Example response: “What you are saying is extremely important, but it may not be safe for others in the room to hear, or even safe for you, lets try and focus on how its impacting on you now.”</p> <p>Readiness for trauma processing – may need to focus on certain stabilisation goals and then it may be ready for processing.</p>
Diversity and groupwork	Discuss adaptations to language, examples and handouts.
<b>DVD 2: Conducting a session ‘Asking for Help’ (60 mins)</b>	<b>Discussion points</b>
Read Chapter of Seeking Safety Manual 2: Conducting the Treatment (pages 32-44)	How would you feedback case management stuff in these scenarios e.g. pregnant client feeling suicidal?
Read Asking for Help Session (Provide photo-copy)	Explore views of the structured format and time-keeping.
Show video of example group-work session with six women, led by Najavits.	

<b>DVD 3: Conducting Grounding techniques (15 mins)</b>	<b>Discussion points</b>
Provide copy of grounding exercise from manual (pages 130-131).  Show video-clip of Najavits conducting this exercise with an individual client.	Explore views on this exercise, and provide suggestions for other grounding techniques to be introduced and the need for repetition throughout the programme.
<b>DVD 4: Adherence (50 mins)</b>	<b>Discussion points</b>
Give copy of the format checklist. Show video of a group-work sessions with 4 women	Discuss and highlight the areas for improvement.

## Appendix 18: Participant Information Sheet



### **Seeking Safety: pilot groupwork programme for women to address substance use and trauma**

I would like to invite you to take part in my PhD research study and use your experiences to help other women. Before you decide, I would like you to understand why the research is being done and what it would involve for you if you decided to take part. If you are interested I will go through the information sheet with you and answer any questions you have. Do feel free to talk to others about the study if you wish or feel free to call or text me (Karen) on tel. **07414 576643** if you have any questions.

### **What is the purpose of the study?**

Many women report using drugs and alcohol to cope with distressing symptoms relating to trauma (such as abuse experienced as a child and/or adult) but there is a lack of interventions in the UK to address their experiences. This study hopes to tackle this problem and help improve services for women. I am carrying out a pilot study to test whether it is possible to deliver an innovative groupwork programme called Seeking Safety at [REDACTED] in partnership with [REDACTED] (a counselling service for women who have experienced any form of gender based violence). The programme aims to help women improve their safety from trauma and substance use by focusing on safe coping skills (such as strategies to deal with post-traumatic stress symptoms, devising a safety plan or thinking in ways that help you feel better). THIS GROUP DOES NOT ASK ANYONE TO DISCUSS TRAUMAS IN DETAIL AND HAS BEEN DESIGNED TO AVOID TRIGGERING PAINFUL MEMORIES.

### **Why have I been approached to take part?**

We know that many women experiencing difficulties with drug or alcohol use have experienced some form of violence or abuse in their lifetimes. Therefore, all women accessing treatment services for alcohol or drug use are being approached to ask if they are interested and eligible to take part. Eligibility will be assessed by myself through a short screening assessment lasting approximately 10-12 minutes (depending on questions you may have) face to face in a private room.

### **Do I have to take part?**

No. It is up to you to decide whether or not you want to take part in the research. If you are eligible and agree to take part, I will ask you to sign a consent form. You are free to withdraw from the study at any time and request to have some or all of your data removed (focus group – four weeks after it takes place; and all other

data up until the 31 May 2018), without giving a reason. This will not affect your access to any of the other services you are currently receiving. Please note that due to the interactive nature of the focus groups it may not be possible to withdraw your data from a focus group, but this can be discussed at the time should it become a concern.

### **What will happen if I agree to take part?**

You will be involved in the research in two ways.

#### **1) Seeking Safety groupwork**

Agreeing to take part means you will be enrolled onto a woman only groupwork programme held at [REDACTED] beginning on 18 Jan 2017. This will require your attendance to 14 sessions held twice weekly (Mons & Thurs) over seven weeks (each session lasting two hours with a 15 minute break). This programme was developed in the USA and is an extremely safe model as it directly addresses both trauma and substance use, **but focuses on the present without requiring clients to go into details about disturbing trauma memories**. It will be delivered by two female facilitators. The programme contains 12 topics such as: *Post-traumatic stress: Taking Back Your Power, Healthy Relationships, Taking Good Care of Yourself, and Detaching from Emotional Pain*.

#### **2) Research interviews**

The second part of the study will ask you to attend three research interviews with myself at three different time points, based in a private room at [REDACTED] (or another support service you are accessing). These interviews will be face to face and last approximately 60 mins and will take place a) approximately 7-14 days before the start of the first groupwork sessions; b) immediately after the groupwork programme ends; and c) 3 months after the end of the groupwork programme. The interview will involve you filling out some questionnaires by yourself and answering some questions I ask you directly. The interviews will cover areas of emotional wellbeing, substance use, experiences of trauma and current safety. I will also collect some personal details such as your age, ethnicity, employment status etc. With your consent, I would also like to access your TOPS assessment that you completed upon first entry to [REDACTED] or the treatment service coordinating your care. At your follow up interviews there will be the option of taking part in an extended final interview which will last 90mins instead of 60 mins and cover additional questions about your experience of the group and how you have been getting on since the group finished. The research interviews will not ask for indepth and descriptive details about your trauma experiences and you can refuse to answer any questions that you wish. You are invited to continue with the interviews even if you choose to stop attending the groupwork programme.



After the end of each groupwork session you will also be asked to complete a very short feedback form (5 mins) to get your views on what you did and did not like about the session. Finally, on the day of the final session, we will hold a focus group (60 mins) to get your more general feedback on what you did and did not like about the entire programme and your ideas for improving it.

You will receive £15 Love2Shop voucher for each interview that you attend and a further £15 voucher for participating in the focus group. This is to thank you for your time. The interviews and focus group will be recorded, subject to your permission. All recordings of data on audio-equipment will be deleted after transcription.

#### **What are the possible benefits of taking part?**

The nature of the groupwork material involves learning about safety and coping strategies for managing distress as well as learning how to keep yourself safe. Research from the USA has shown that learning these strategies can help improve your mental health and reduce substance use. You may also find it useful to take part in a groupwork programme with other women who have had similar experiences. In addition you will be helping to shape and improve a brand new programme that we can offer to other women in the future.

#### **What are the possible disadvantages and risks of taking part?**

The assessment questionnaires will ask about specific experiences of violence and abuse and other traumas (inc. frequency and your approx. age at the time), and as such may bring up distressing memories or feelings. However, I will not ask for details or descriptions, you may refuse to answer any questions, stop the interview at any point and there will be staff around to support you afterwards.

#### **Will my taking part be kept confidential?**

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. The audio recordings from the interview and focus groups will contain only your study ID (not your name). With permission from all group members I will video- record the groupwork sessions. I will be doing this *only* to check the facilitators are running the group as planned. All recordings will be stored on a secure computer with password protection and will only be shared with my two supervisors and the programme author Lisa Najavits who is supporting me in my study. What you say in the interviews will be typed out word for word. I will check this text to make sure you and anyone you mention are not identifiable from what you have said. We may use direct quotes from your interview in publications or reports but the data will be anonymised to

protect your identity and you will not be identifiable. The interviews and the data will be kept on a computer and will be stored separately from your contact details.

Limitations to the confidentiality described, include the following circumstances:

- where a child is suspected of being at risk of current/future harm
- where yourself or another person is at risk of current/future harm

If I believe that there is a realistic risk of serious harm to yourself or someone else who is specifically identified, I will be under an obligation to tell staff at [REDACTED] or the partner service coordinating your care (if the interview is taking place there) who will then follow their service safeguarding procedures which may involve sharing information with other services in line with the local Islington consent to liaise form. *We can stop the interview at anytime if you become distressed.*

### **Further enquiries**

If you have any general enquiries about the study please contact me on [Karen.bailey@kcl.ac.uk](mailto:Karen.bailey@kcl.ac.uk) or tel. **07414 576643**. If this study has harmed you in any way please contact my supervisor Dr Gail Gilchrist at [gail.gilchrist@kcl.ac.uk](mailto:gail.gilchrist@kcl.ac.uk) or tel. 020 7848 0646. Our postal address is National Addiction Centre, Institute of Psychiatry, Psychology and Neuroscience (IOPPN) King's College London 4 Windsor Walk, Denmark Hill, London SE5 8BB.

### **What will happen to the results of the research study?**

I will produce a final report summarising the main findings as part of my doctoral thesis and will also try and produce an article for publication. You can receive a copy of the summary findings of this pilot by indicating on the consent form.

### **Who is organising and funding the research?**

I am being funded through a grant from the Economic and Social Research Council and the groupwork programme is being funded by a grant from Alcohol Research UK and through the support of [REDACTED] misuse service.

### **Who has reviewed the study?**

All research at Kings College London is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Psychiatry, Nursing and Midwifery Research Ethics Subcommittee at Kings College London (Ref: HR-16/17-4598).

## Appendix 19: Participant consent forms

### **CONSENT FORM**

**Project: Seeking Safety: pilot groupwork programme for women to address substance use and trauma**

**Name of Researcher: Karen Bailey**

Please initial the box if you consent to

#### **A. Screening stage**

1. I agree to my anonymised data being used in the research even if I do not meet the eligibility criteria to go forward with the study. ☐

#### **B. Assessment stage**

Please initial all boxes you consent to

1. I confirm that I have read and understand the information sheet dated Version 5. 07/11/2017 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw from the study at any time up until the 31 May 2018 (focus group data up to 4 weeks after it takes place) without giving any reason, without my care or legal rights being affected. ☐
3. I acknowledge that the confidentiality of my focus group contributions cannot be absolutely guaranteed. This is due to the interactive and interdependent nature of focus group participation. ☐
4. I understand that the anonymised data from this study may be published at the end of the study and that anonymised quotations from the interview may be used in the report/publications. ☐
5. I give permission for the researcher to access my treatment entry TOPS assessment. ☐
6. I give permission for the anonymised project summary to be sent by email/post/given to me in person (delete as appropriate). ☐
7. I understand that I must attend the Women's Day Programme at Cranstoun 28b services and continue to do so throughout the duration of the study. ☐
8. I understand the limitations to confidentiality and if this happens, I understand that the researcher will need to speak to staff at Cranstoun. ☐
9. I understand the final interview will be audio recorded and the groupwork sessions will be video-recorded and I agree to take part in the above study. ☐

Name of Participant \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

Name of Researcher \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

Version 5. 07/11/17

## **CONSENT FORM (addendum 3 to Consent Form v5 07.11.17)**

**Project: Seeking Safety: pilot groupwork programme for women to address substance use and trauma**

**Name of Researcher: Karen Bailey**

Please initial the box if you consent to

☐

1. I agree to a selection of video recorded sessions to be shared with the Seeking Safety programme author Lisa Najavits

Name of Participant \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

Name of Researcher \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

## Appendix 20: Study advertisement



REC reference: HR-16/17-4598

**Are you a woman who has experienced violence or abuse as a child or adult?**

**Would you like to take part in a women only groupwork programme to help and support you to manage your emotions and drug/alcohol use?**

**Would you like to use your experiences by taking part in a research study and helping other women in the future?**

**The group does not ask you to talk about your trauma – it focuses on providing skills to cope with the impacts on your life today.**

We are looking for women to take part in a study starting in Oct which involves:

- 13 sessions of a groupwork programme called Seeking Safety
- 3 private interviews with a researcher (1 hour each)
- 1 focus group with a researcher (1 hour)

The interviews ask questions about your emotional wellbeing, substance use and the type of violence and abuse, as well as experiences of taking part in the groupwork programme.

**Sessions include: Post-Traumatic Stress: Taking Back Your Power, Healthy Relationships, Taking Care of Yourself, Healing from Anger, Detaching from Emotional Pain**

**Find out more**  
**Contact Karen in confidence on tel. 07414 576643 or [karen.bailey@kcl.ac.uk](mailto:karen.bailey@kcl.ac.uk)**

**You will receive a £15 voucher for each interview /focus group you take part in to thank you for your time.**

V1 08.08.17

## Appendix 21: Feasibility study measures

Questionnaire	Description	Variables	Period	T1	T2	T3
<i>Participant characteristics</i>	Mixture of socio-demographic information and mental health status in order to provide participant characteristics relevant to the study.	<ul style="list-style-type: none"> <li>• Age</li> <li>• Ethnicity</li> <li>• Sexual Orientation</li> <li>• Disability</li> <li>• Education</li> <li>• Migrant status</li> <li>• No. of children &amp; location, social services involvement</li> <li>• Medication</li> <li>• Mental Health Diagnosis</li> <li>• Ever received help from mental health services.</li> </ul>		X		
	Descriptive variables that may change throughout the study and provide contextual information to be followed up in analysis.	<ul style="list-style-type: none"> <li>• Employment status</li> <li>• Living situation</li> <li>• Kind of accommodation</li> <li>• Relationship status</li> </ul>		X	X	X
	Inclusion/Exclusion criteria.	<ul style="list-style-type: none"> <li>• Unwell from suicidal thoughts in past 3 months</li> <li>• Currently Receiving help for PTSD</li> </ul>		X		
<i>Service receipt inventory</i>	Ancillary services received at the study treatment service or from outside providers.	<ul style="list-style-type: none"> <li>• Groupwork (number of sessions of groupwork attended at any substance use treatment service);</li> <li>• Keywork (number of sessions of keywork attended at any substance use treatment services);</li> <li>• Counselling (number of sessions of counselling attended at any service);</li> <li>• Alternative Therapies (number of sessions of acupuncture, yoga, massage or cranial-sacral therapy attended);</li> <li>• Peer support (number of peer support events attended including social events, 12-step meetings or SMART recovery meetings);</li> <li>• Health (number of GP, nurse, hospital visits).</li> </ul>	Since last assessment		X	X

Questionnaire	Description	Variables	Reason for choice	Period	T1	T2	T3
<i>PTSD checklist for DSM-5 (PCL-5)</i> [Weathers et al., 2013]	The PCL-5 is a 20 item self-report measure that assesses the 20 DSM-5 symptoms of PTSD and can provide a provisional diagnosis and/or determine mean change. The previous version of the PCL has been validated in over 20 studies, including with women in primary care, and found to have good psychometric properties (McDonald et al., 2010).	<p>Participants are asked to keep their worst event in mind and score themselves to indicate how bothered they have been by the symptoms in the past month ("Not at all"=0, "A little"=1, "Moderately"=2, "Quite a bit"=3, "Extremely"=4).</p> <p><i>Summary variables</i></p> <ul style="list-style-type: none"> <li>• Total score variable [range 0-80]</li> <li>• Dichotomous variable indicating the presence of a potential PTSD diagnosis calculated by treating each item rated as 2 = "Moderately" or higher as a symptom endorsed, then following the <i>DSM-5</i> diagnostic rule which requires at least: 1 B item (questions 1-5), 1 C item (questions 6-7), 2 D items (questions 8-14), 2 E items (questions 15-20).</li> <li>• Clinically meaningful change (≥10pts) (Monsoon et al., 2008) based on DSM-4<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Aligned to DSM-5, can be used to identify provisional diagnosis;</li> <li>• Guidance available on measuring sub-threshold PTSD (Brançu et al 2016);</li> <li>• Guidance on measuring clinical meaningful change (Weathers et al., 2013);</li> <li>• Has an accompanying brief assessment for Criterion A (i.e. type of trauma);</li> <li>• Self-report &amp; doesn't require a clinical interview;</li> <li>• Brief (5-10 mins).</li> </ul>	Last 30 days	X	X	X
WCDVS version of the Life Stressor Checklist-Revised (LSC-R)	The LSC-R is specifically tailored to trauma exposure and life events of women. It has demonstrated good content validity (Wolfe & Kimmerling, 1997) and criterion-related validity for PTSD in diverse populations of women (Brown, Stout & Mueller; Kimmerling & Calhoun, 1999; Brown, Stout & Mueller, 1999). The modified version has been tested in a large sample of women (n=3,000) for tolerability and breadth and scope of possible traumatic events affecting women, and showed good test-	<p>Summary variables **</p> <ul style="list-style-type: none"> <li>• <i>Lifetime exposure to stressful events</i> (LESE) used information from all 33 specific items to indicate the breadth of exposure to lifetime stressful events. A score on the LESE is equal to the total number of items endorsed (Range = 0-33);</li> <li>• <i>Lifetime frequency of interpersonal abuse</i> (LFIPA) uses follow-up probe information from 10 items (Appendix 22 items 17, 18, 19, 20, 21, 24, 30, 31, 32, 33) to quantify the frequency of lifetime IPA; response options are "never" (0), "once" (1), "a few times" (2), or "a lot" (3). Four of the 10 items (Appendix 22 items 20, 21, 30, 31) ask about frequency of abuse in both childhood and adulthood, and thus 14</li> </ul>	<ul style="list-style-type: none"> <li>• Gender –sensitive assessment of trauma to assess for highly stressful events which may fall outside of DSM criteria for trauma, but may contribute to psychological distress;</li> <li>• Complementary to formal PTSD assessments and describes quantitatively the complexity and severity of traumatic events experienced by women;</li> <li>• Relatively short – takes 15-20 minutes to administer.</li> <li>• The systematic review (Chapter 3) identifies the importance of measuring for repeat IPA over the course of the study</li> </ul>	Lifetime & past six months	X	X exposure since last assessment	

	retest reliability (McHugo et al 2005).	<div>responses were summed (Range = 0-42);</div> <div></div> <ul style="list-style-type: none"><li>• <i>Exposure to childhood sexual abuse (CSA)</i> is a binary variable indicating the presence of childhood sexual abuse calculated as 1 if a positive answer is given to either items 30b or 31b.</li><li>• <i>Exposure to childhood physical abuse (CPA)</i> is a binary variable indicating the presence of childhood physical abuse calculated as 1 if a positive answer is given to either items 20b or 21b.</li><li>• <i>Exposure to adult sexual abuse (CSA)</i> is a binary variable indicating the presence of adult sexual abuse calculated as 1 if positive answer is given to either items 30c or 31c.</li><li>• <i>Exposure to adult physical abuse (CPA)</i> is a binary variable indicating the presence of adult physical abuse calculated as 1 if a positive answer is given to either items 20c or 21c.</li><li>• <i>Current exposure to interpersonal abuse (CEIPA)</i> consists of the summed responses ("no" = 0; "yes" = 1) to 9 items pertaining to IPA experienced in the past 6 months (Appendix 22 items 18, 19, 20, 21, 24, 30, 31, 32, 33)</li><li>• <i>Current exposure to other stressful events (CEOS)</i> consists of the summed responses ("no" = 0; "yes" = 1) to all other stressful events not included in the CEIV variable in the past 6 months [range 0-21].</li><li>• <i>IPA experienced since the last assessment (IPA-new) (T2&amp;T3)</i> consists of the summed responses ("no" = 0; "yes" = 1) to 9 items pertaining to new exposure to any IPA since the last assessment (Appendix 22 items 18, 19, 20, 21, 24, 30, 31, 32, 33)</li></ul>					
Composite Abuse Scale (Revised)—Short Form (CASR-SF)	Comprehensive, valid and reliable brief self-report measure of 15 items capturing physical, sexual and psychological abuse and overall intimate partner violence. It retains the strengths of the longer 30 item CAS (Hegarty et al., 2005) and has been tested in a large sample of	<ul style="list-style-type: none"><li>• <i>Presence of any lifetime intimate partner abuse</i> is a dichotomous variable indicating the presence of any form of intimate partner abuse (15 items) in a woman's lifetime;</li><li>• <i>Exposure to lifetime intimate partner abuse</i> is the summed responses ("yes"=1, "no"=0) to the 15 forms of abuse [range 1-15];</li></ul>	<ul style="list-style-type: none"><li>• Captures all forms of intimate partner abuse with focus on severity and intensity of experiences;</li><li>• Shorter version – quicker to administer.</li></ul>	12 months + 1 month (T1)  Since last assessment and 1 month (T2 & T3)	X	X	X



	Canadian women (Ford-Gilboe et al 2017).	<ul style="list-style-type: none"><li>• <i>Presence of intimate partner abuse in the past 12 months</i> is a dichotomous variable indicating the presence of any form of abuse (15 items) in the past 12 months;</li><li>• <i>Frequency of intimate partner abuse in the past 12 months</i> consists of the summed responses for each of the 15 items of abuse (0="not in past 12mths", 1="once", 2="a few times", 3="monthly", 4="weekly", 5="daily/almost daily") [range 0-75];</li><li>• The <i>Composite Abuse Score</i> (Ford-Gilboe et al., 2017) consists of the mean of frequency of past 12 month scores multiplied by 15 where there are responses for at least 11 of 15 items [range 1-75]. A higher score indicates more severe and frequent abuse;</li><li>• <i>Presence of intimate partner abuse since the last assessment</i> is the summed responses ("yes"=1, "no"=0) to the 15 forms of abuse [range 1-15] experienced in the last month;</li><li>• <i>Frequency of intimate partner abuse since the last assessment</i> consists of the summed responses for each of the 15 items of abuse (0="not since we last spoke", 1="once", 2="a few times", 3="monthly", 4="weekly", 5="daily/almost daily") [range 0-75];</li><li>• <i>Presence of intimate partner abuse in the past month</i> is a dichotomous variable indicating the presence of any form of abuse (15 items) in the past month.</li></ul>					
<i>Brief version of the Posttraumatic Cognitions Inventory – (PTCI-9) (Wells et al. 2017)</i>	The full version of the PTCI has demonstrated good psychometric properties in mixed trauma samples (Foa et al., 1999) and with women who have experienced sexual assault (Andreu et al., 2016) and used with samples experiencing comorbid PTSD and alcohol problems (Foa & Williams, 2010). A shortened 9-item version has recently been developed and showed strong correlation with the full inventory among a group of female participants with and without PTSD (Wells et al 2017).	Women were asked to indicate how much they agreed with a series of 9 statements using a Likert scale of 1-7. ("Totally disagree"=1 to "Totally agree" =7) [range 9-63]. Three statements pertained to negative cognitions about self (e.g. "I have no future"), three statements related to negative cognitions about the world (e.g. 'people can't be trusted") and three related to self blame (e.g. "the event happened because of the way I acted.") <ul style="list-style-type: none"><li>• A total score variable was created, with a higher score indicating more negative cognitions.</li></ul>	<ul style="list-style-type: none"><li>• Reducing negative cognitions thought to be a key mechanism of change in PTSD treatment (Kleim et al., 2012, Cloitre et al, 2004)</li><li>• A 15 item version measure was used in the above study</li><li>• Quick to complete</li></ul>	N/A	X	X	X

ASI –Drug composite and ASI-Alcohol composite scores of the Addiction Severity Index (McLellan, 1980).	The composite scores are based on reported use and perceived problem severity during the past 30 days. They have been found to be a reliable and valid measures of current patient status (McLellan et al., 1985; Comfort et al., 1999). Studies of women and psychiatric patients have reported favorable test-retest reliability and internal consistency [Comfort et al., 1999, Hodgins & el-Guebaly, 1992].	<p>The following composite scores were calculated following the guidance of McGahan et al., (1996):</p> <ul style="list-style-type: none"> <li>The <i>Alcohol Composite Score</i> was calculated from the sum of scores to six questions: Three questions relating to past 30 days (days of any alcohol use, days of use to intoxication and days bothered by any alcohol problems) are each divided by 30, the number of days, and by 6, the total number of questions in the composite. The answers to two questions relating to being bothered by these alcohol problems in past 30 days and the importance of treatment (“not at all”=0, “slightly”=1, “moderately”=2, “considerably”=3, “extremely”=4) are each divided by 4, the highest scale value. They are also divided by 6 the number of questions. The log of the answer to the sixth question relating to money spent on alcohol in the past 30 days is divided by 6, the number of questions and by 7.3, the highest log value. A higher score indicates a higher level of problem severity.</li> <li>The <i>Drug Composite Score</i> was calculated from the sum of the scores from 13 questions. Ten questions relating to 30 day use of different substances (excluding alcohol) and the question relating to the number of days experiencing drug problems are each divided by 30, the number of possible days, and by 13, the total number of questions used. Two questions relating to participant rating of how bothered they have been by drug problems in the past 30 days and the importance of treatment (“not at all”=0, “slightly”=1, “moderately”=2, “considerably”=3, “extremely”=4) are divided by 4, the highest possible response, and by 13, the number of variables. A higher score indicates a higher level of problem severity.</li> </ul>	<ul style="list-style-type: none"> <li>Provides measure of change based on days of usage in past 30 days;</li> <li>Asks how much spent on substances in last 30 days</li> <li>Provides indication of historic regular use;</li> <li>Used in several studies identified in systematic review, (Chapter 3) (Triffleman, 2000; McGovern, 2015; Perez-Dandieu, &amp; Tapia 2014; Fallot et al., 2011; Amaro et al., 2007; Toussaint et al., 2007; Desai et al., 2008).</li> </ul>	Last 30 days	X	X	X
The Patient Health Questionnaire	The PHQ-9 is a self-completed measure of depression widely used in the UK (Spitzer et al.,	<ul style="list-style-type: none"> <li>A total score was calculated by summing the responses (“not at all”=0, “several days”=1, “more than half the days”=2,</li> </ul>	High level of co-morbidity between depression and PTSD in survivors of IPV (Resick et al.,	Past 2 weeks	X	X	X

(PHQ-9) (Spitzer et al. 1999)	1999) aligned to the diagnostic criteria for depression and has extensive validation in diverse populations with sensitivity to change (Gilbody et al., 2007).	<p>“nearly every day”=3) to the 9 items [range 0-27]. A higher scores indicates more severe levels of depression.</p> <ul style="list-style-type: none"> <li>A dichotomous variable was created to indicates the presence of clinical depression as defined by a score of 10 or more (Hegarty et al., 2013b, Gunn et al., 2006).</li> </ul>	<p>2002, Nishith et al., 2005; O'Campo et al., 2006, Trevillion et al 2012).</p> <p>Associated with substance use (Davis et al 2008; Gossop, Hobden et al., 2018; Marsden &amp; Stewart, 2006)</p> <p>Negative mood suggested as potential mediator of PTSD outcome (Cloitre et al., 2004)</p>				
The Difficulties in Emotion Regulation Scale (DERS) –Short Form Kaufman et al 2015)	DERS is a well validated and widely used self-report measure for assessing emotion regulation problems among adolescents and adults (Jankowski 2013, Orgeta 2009). A shortened version comprising 18 items has been developed and shown to have excellent psychometric properties, retaining the total and subscale scores of the original measure with half the items (Kaufman et al 2015, Victor & Klonsky 2016).	<p>A variable was created indicating the total score from responses to the 18 items covering the 6 domains of Strategies (e.g. “when I am upset, I believe I will end up feeling very depressed”), Non-acceptance (e.g. “when I am upset I have difficulty controlling my behaviours), Impulse (e.g. “When I am upset it takes me a long time to feel better”), Goals (e.g. “When I am upset, I have difficult getting work done”), Awareness (e.g. “I pay attention to how I feel”), and Clarity (e.g. “I have no idea how I am feeling”).</p> <p>Women were asked to score themselves (“Almost never”=1, “Sometimes”=2, “About half the time”=3, “Most of the time”=4, “Almost Always”) [range 18-90]. Three items required reverse coding and a variable created for the total score, with a higher score indicating more severe problems with emotional regulation.</p>	<ul style="list-style-type: none"> <li>Potential mechanism of change as identified in the literature review (Phase 1, chapter 3) (Price et al 2012, Weiss et al 2013, 2013b, Tull et al., 2015).</li> </ul>	N/A	X	X	X
Rosenberg Self Esteem Scale (RSE) (Rosenberg 1965)	The RSE is one of the most widely used measurements of self-esteem and comprises 10 self-report items. It has shown high internal reliability among female survivors of sexual or physical abuse (Kubany et al., 2005)	A total score variable was created from the responses to 10 statements. Women were asked to rate how much they agreed with the statements (e.g. “I wish I could have more respect for myself”, “I feel I do not have much to be proud of”) using a four-point Likert scale (“Strongly agree”=3, “Agree”=2 “Disagree”=1, “Strongly Disagree”=0). Five items were reverse coded to create a total score [range 0-30]. The higher the score indicates higher levels	<ul style="list-style-type: none"> <li>Potential mechanism of change as suggested in Consultation with stakeholder (Phase 2, chapter 4)</li> </ul>	N/A	X	X	X

		of self-esteem with an estimated threshold of 15 indicating low self-esteem (Rosenburg 1965).					
Social Provisions Scale (SPS) (Cutrona & Russell 1987)	SPS is a self-report measure of 24 items which respondents rate on a four-point scale. The SPS has shown good reliability and validity among students and professional groups (Cutrona & Russell, 1987)	A total score variable was created from responses to statements covering 6 areas of provision: Attachment (e.g. "I feel that I do not have close personal relationships with other people"), Social Integration (e.g. "there are people who enjoy the same social activities that I do"), Reassurance of Self-worth (e.g. "Other people do not view me as competent), Reliable Alliance (e.g. "There are people I can depend on to help me if I really need it), Guidance (e.g. "There is no-one I can turn to for guidance in times of stress) and Opportunities for Nurturance (e.g. "there are people who depend on me for help"); using the following responses ("Strongly disagree"=1, "Disagree"=2, "Agree"=3, "Strongly disagree"=4). Twelve items were reverse coded, with a higher score indicating the presence of more social support provision [range 24-96].	<ul style="list-style-type: none"> <li>• Social support as a potential moderator for successful substance use and PTSD treatment outcomes as identified in literature review (phase 1, chapter 3) and in wider literature on substance use (Litt et al. 2009; Moos 2007) and IPA (Constantino et al 2005;</li> <li>• Recommended in a recent review of social support measures (Gottlieb &amp; Bergen 2010)</li> <li>• Can provide composite scores for different elements of social support such as advice and guidance (Guidance) as well as composites which relate to boosting self-efficacy (Re-assurance of worth)</li> </ul>	N/A	X	X	X
Core Components of Treatment Scale (Najavits et al. 1995) – Modified version	This scale is an adapted version comprising a self-report measure of 18 different coping skills taught in the Seeking Safety intervention and has shown good internal consistency with this study population (Gatz et al 2007).	<p>Questions covered cognitive skills (e.g. "thinking in a way that helps you feel better), self-care (e.g. "doing something that makes you feel good"), and interpersonal skills (e.g. "do something to protect yourself from others who would harm you physically or emotionally").</p> <p>A total score variable was created from the 18 items plus the addition of one new item to measure the coping skill relating to grounding skills, reflecting the introduction of the comfort kit and additional grounding exercises introduced by the facilitators. This question was worded as "the use of breathing, touch, sound, smell, sound or taste to feel better." Women were asked to rate how often they used the coping skills in the past 30 days ("Not at all=0, "A little"=1, "Somewhat"=2, "Moderately"=3, "A lot"=4, "Extremely"=5). A higher score indicates</p>	<ul style="list-style-type: none"> <li>• Measures the core skills taught in the Seeking Safety programme</li> <li>• Coping skills found to be mediator for reducing psychological distress and drug use in one study of Seeking Safety (Gatz et al., 2007) and is implicated in better substance use treatment outcomes in wider research samples (Moos 2007).</li> </ul>	Past 30 days	X	X	X

		the presence of more frequent use of coping skills [range 0-95].					
California Psychotherapy Alliance Scale (CALPAS-G) for groups (Gaston & Marmar 1994)	The CALPAS-G is a 12 item measure of group alliance, , and cohesion which is closely aligned to the widely used CALPAS used in individual therapy (Marmar & Gaston 1994). The CALPAS has shown good internal consistency and inter-rater reliability (Cecero et al., 2001; Fenton et al., 2001) and the CALPAS-G has been shown to effectively assess group cohesion in patients with depression (Crowe & Grenyer, 2008).	<p>Four variables were created comprising the mean of each of the 4 subscales. Completed by the group participants only, the measure comprises the domains comprise Patient Working Capacity (e.g. "When important things come to mind, how often did you find yourself keeping them to yourself rather than sharing them with the group?"); Patient Commitment (e.g. "Did you feel that even if you might have moments of doubt, confusion or mistrust, that overall therapy was worthwhile?");</p> <p>Working Strategy Consensus (e.g. "Did you feel that you were working together with the group members, that you were joined in a struggle to overcome your problems?"); and Member Understanding and Involvement (e.g. "Did you feel accepted and respected by the group members for who you are?"). Women were asked to rate how well each question describes their experience in the group using a 6-point Likert ranging from "Not at all=0" to "Very much so=6". After reverse coding for 6 items, a mean score +1 was calculated for each subscale (Gaston &amp; Marmar 1989).</p>	<ul style="list-style-type: none"> <li>Group cohesion has been shown to correlate with therapy outcomes in meta-analysis (Burlingame, McClendon &amp; Alonso, 2011).</li> <li>There is some evidence that perception of group cohesion may be better predictors of outcome than client-therapist alliance (Crowe &amp; Grenyer, 2008).</li> </ul>			X	
Hatcher-Gillaspay Short Form of the Working Alliance Inventory (WAI-SF) (Hatcher & Gillaspay 2006)	The WAI-SF is an adapted version of the original WAI (Horvath 1981) and consists of a client version (12 items) and corresponding therapist version (10 items). It has shown good internal consistency and high reliability (Horvath & Gillaspay, 2007; Munder et al., 2010).	<p>Four score variables were calculated using the mean score from both therapists' ratings of the participants and mean score from the client rating of each therapist. Facilitators and group participants were asked to respond to a 6 point Likert scale for questions covering 3 domains, with higher scores representing higher working alliance.</p> <p>Goal items reflect the mutual contribution of the client and therapist to goal setting (e.g. "As a result of these sessions I am clearer as to how I might be able to change"), the Bond items reflects client opinions on being appreciated and liked by the therapist (e.g. "I believe [therapist name] likes me") and the Task items focus on the idea that the key to effective treatment is the therapist's ability to help the client see how the tasks of therapy will lead to achieving the therapeutic goals (e.g. I believe the way we are working on my problem is correct).</p>	<ul style="list-style-type: none"> <li>Meta-analysis has suggested that therapeutic alliance plays a part in accounting for outcomes across a range of psychotherapy (Horvath et al., 2011).</li> <li>Therapeutic alliance was related to retention and PTSD reductions in the Women and Trauma Study (Pinto et al., 2011; Ruglass et al., 2012).</li> </ul>			X	

## Appendix 22: WCDVS version of the Life-Stressor Checklist-Revised

(obtained from WCDVS researcher)

### Lifetime Trauma Assessment (Baseline only)

*Now I am going to ask you some questions about life events that are upsetting or stressful to most people. Some of these questions may not apply to you, but I have to ask them as written. Please think back over your whole life when you answer these questions. Some of these questions may be about upsetting events you don't usually talk about. Your answers are important to us, BUT you DO NOT have to answer any questions that you do not want to. Also remember that your answers are completely confidential and will be used only for research purposes.*

*Interviewer note: For each question if the respondent asks or appears unsure, read the statement in parentheses to clarify what is being asked)*

**B.1 Have you ever been in a serious disaster? (If asked, say 'This would include events like an earthquake, hurricane, large fire, explosion, or other disasters.')**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

If NO, skip to B.2

**B.1.a Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.2 Have you ever had a serious accident or an accident-related injury?**

**(If asked, say, "This would include events like a bad car wreck, a household fire, or an on-the-job accident.")**

1 = Yes; 0 = No; -6 = Ref; 7 = DK; 8 = NA; 9 = Missing

If NO, skip to B.3

**B.2.a Has this happened in the past six months?**

1 = Yes; 0 = No; -6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.3 Was a close family member ever sent to jail?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

If NO, skip to B.4

**B.3.a Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.4 Have you ever been sent to jail or attended youth offending service?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

If NO, skip to B.5

**B.4.a Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.5 Were you ever put in foster care or put up for adoption?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.6 Did your parents ever separate or divorce while you were living with them? By your parents, I mean your biological parents or any couple who acted as parents to you.**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.7 Have you ever experienced the breakup of a long-term committed relationship? This would include being separated, abandoned, or divorced.**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

If NO, skip to B.8

**B.7.a Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.8 Have you ever been homeless? By homeless, I mean that you did not have a regular place to stay and that you had to stay in a shelter or a place that is not meant for housing, like a public place, car, or an abandoned building.**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

If NO, skip to B.9

**B.8.a Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.9 Have you ever had serious money problems? (If asked, say "This would include not having enough money for food, clothing, housing, or transportation.")**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

If NO, skip to B.10

**B.9.a Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.10 Have you ever had a very serious physical or mental illness?**

**(If asked, say "This would include cancer, heart attack or a serious operation; or tried to kill yourself or been hospitalized because of psychological distress")**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

If NO, skip to B.11

**B.10.a Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.11 Have you ever had an abortion?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

If NO, skip to B.12

**B.11.a Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.12 Have you ever had a miscarriage? (If asked, say: "Lost a baby?")**

1 = Yes; 0 = No; -6 = Ref; -7 = DK; -8 = NA; -9 = Missing

If NO, skip to B.13

**B.12.a Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; -8 = NA; 9 = Missing

**B.13 Has a child of yours ever died? This would include death at birth.**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

If NO, skip to B.13

**B.13.a Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.13.1 Have you ever been separated from your child(ren) against your will? (If asked, say "This would include the loss of custody or visitation, by kidnapping, or because of an institutionalization")**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

If NO, skip to B.14

**B.13.1.a Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.14 Has a baby or child of yours ever had a severe illness, injury, or disability?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

If NO, skip to B.15

**B.14.a Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.15 Have you ever been responsible for taking care of someone close to you, OTHER THAN YOUR CHILD, who had a severe illness, injury, or disability?**

1 = Yes; 0 = No; -6 = Ref; -7 = DK; -8 = NA; -9 = Missing

If NO, skip to B.16

B.15.a Have you had responsibility for this person in the past six months?

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.16 Has anyone close to you, OTHER THAN YOUR CHILD, ever died suddenly or unexpectedly? (If asked, say "This would include sudden heart attack, murder, or suicide.")**

1 = Yes; 0 = No; -6 = Ref; -7 = DK; -8 = NA; -9 = Missing

If NO, skip to B.17

B.16.a Has this happened in the past six months? B.16.a 1 0 -6 -7 -8 -9

1 = Yes; 0 = No; -6 = Ref; -7 = DK; -8 = NA; -9 = Missing

*For this next set of questions, I will start by asking if a particular event has happened to you, and you answer "Yes" "No" or Don't Know". If you say that a particular kind of event happened to you, then I will ask you how many times it happened. Your answer can be "once," "a few times" or "a lot". "A few times" means that there were only a few occasions. "A lot" means that this happened repeatedly, or that it happened so many times that you cannot remember them all. (Give participant Card #1) I will also ask you about your age when the event first happened. Rather than giving me your exact age when it first happened, please tell me your approximate age using these 5 categories. (Give participant Card #2): 0-5 years old or before you started school; 6-10 years old or when you were in primary school; 11-13 years old or when you were middle or secondary school; 14-17 years old or when you were in secondary or upper school/college; and 18 years or older.*

**B.17 When you were young before age 18, did you ever see physical violence between family members? (if asked, say "This would include hitting, kicking, punching, and other acts like these.")**

1 = Yes; 0 = No; -6 = Ref; -7 = DK; -8 = NA; -9 = Missing

If NO, skip to B.18

B.17.a How often did this happen?

1 = Once 2 = A few times 3 = A lot

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.17.b Using only the first 4 categories on Card #2, how old were you when this (first) happened?**

1 = 0-5 yrs/before started school

2 = 6-10 yrs/middle

3 = 11-13 yrs middle/secondary school

4 = 14-17 yrs/secondary/upper school

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.18 Thinking about across the life time, have you ever been emotionally abused or emotionally neglected?**

**(If asked, say "This would include being frequently shamed, embarrassed, ignored, repeatedly told you were 'no good', or other experiences like these.)**

1 = Yes; 0 = No; -6 = Ref; -7 = DK; -8 = NA; -9 = Missing

If NO, skip to B.19

**B.18.a How often has this happened across your lifetime?**

1 = Once 2 = A few times 3 = A lot

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.18.b How old were you when this (first) happened?**

1 = 0-5 yrs/before started school

2 = 6-10 yrs/middle

3 = 11-13 yrs middle/secondary school

4 = 14-17 yrs/secondary/upper school

5 = 18 yrs or older

6 = Refused; 7 = DK; 8 = NA; 9 = Missing



**B.18.c Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.19 Have you ever been physically neglected? (If asked, say "This would include not fed, not properly clothed, left to take care of yourself when you felt you were too young or too ill.")**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

If NO, skip to B.20

**B.19.a How often has this happened?**

1 = Once 2 = A few times 3 = A lot

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.19.b How old were you when this (first) happened?**

1 = 0-5 yrs/before started school

2 = 6-10 yrs/middle

3 = 11-13 yrs middle/secondary school

4 = 14-17 yrs/secondary/upper school

5 = 18 yrs or older

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.19.c Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.20 Have you ever been physically abused by someone you knew well?**

**This would include a family member, boyfriend or girlfriend, spouse, or someone else you knew well. Physical abuse includes being hit, choked, burned, beaten, locked up, tied up or chained, kidnapped or held hostage, or other experiences like these.**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

If NO, skip to B.21

**B.20.a How old were you when this (first) happened?**

1 = 0-5 yrs/before started school

2 = 6-10 yrs/middle

3 = 11-13 yrs middle/secondary school

4 = 14-17 yrs/secondary/upper school

5 = 18 yrs or older

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

If "18 years or older" skip to B.20.c

**Substitute Card #1 for Card #1a**

**B.20.b How often did this happen before age 18?**

0 = Never 1 = Once 2 = A few times 3 = A lot

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.20.c How often has this happened since you turned 18?**

0 = Never 1 = Once 2 = A few times 3 = A lot

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.20.d Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.21 Have you ever been physically abused or attacked by a stranger or by someone you did not know well? For example this would include being hit, strangled, burned, beaten, stabbed, shot at, locked up, tied up or chained, kidnapped or held hostage, or other experiences like these.**

1 = Yes; 0 = No; -6 = Ref; -7 = DK; -8 = NA; -9 = Missing

If NO, skip to B.22

**B.21.a How old were you when this (first) happened?**

1 = 0-5 yrs/before started school

2 = 6-10 yrs/middle

3 = 11-13 yrs middle/secondary school

4 = 14-17 yrs/secondary/upper school

5 = 18 yrs or older

6 = Refused; 7 = DK; 8 = NA; 9 = Missing  
If "18 years or older" skip to B.21.c

**B.21.b How often did this happen before age 18?**

0 = Never 1 = Once 2 = A few times 3 = A lot  
6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.21.c How often has this happened since you turned 18?**

0 = Never 1 = Once 2 = A few times 3 = A lot  
6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.21.d Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; -8 = NA; 9 = Missing

**Replace Card #1a with Card #1**

**B.22 Have you ever been robbed or mugged?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; -8 = NA; 9 = Missing  
If NO, skip to B.23

**B.22.a How often has this happened?**

1 = Once 2 = A few times 3 = A lot  
6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.22.b How old were you when this (first) happened?**

1 = 0-5 yrs/before started school  
2 = 6-10 yrs/middle  
3 = 11-13 yrs middle/secondary school  
4 = 14-17 yrs/secondary/upper school 5 = 18 yrs or older  
6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.22.c Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; -8 = NA; 9 = Missing

**B.23 Have you ever seen a robbery, a mugging or an attack taking place?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing  
If NO, skip to B.24

**B.23.a How often has this happened?**

1 = Once 2 = A few times 3 = A lot  
6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.23.b How old were you when this (first) happened?**

1 = 0-5 yrs/before started school  
2 = 6-10 yrs/middle  
3 = 11-13 yrs middle/secondary school  
4 = 14-17 yrs/secondary/upper school  
5 = 18 yrs or older  
6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.23.c Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.24 Have you ever been stalked, or has anyone ever threatened to kill you or seriously harm you?**

1 = Yes; 0 = No; -6 = Ref; -7 = DK; -8 = NA; -9 = Missing  
If NO, skip to B.25

**B.24.a How often has this happened?**

1 = Once 2 = A few times 3 = A lot  
6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.24.b How old were you when this (first) happened?**

1 = 0-5 yrs/before started school  
2 = 6-10 yrs/middle  
3 = 11-13 yrs middle/secondary school  
4 = 14-17 yrs/secondary/upper school

5 = 18 yrs or older

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.24.c Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.25 Have you ever been involuntarily committed for a psychiatric evaluation? Have you ever been taken for a psychiatric evaluation against your will?**

1 = Yes; 0 = No; -6 = Ref; -7 = DK; -8 = NA; -9 = Missing

If NO, skip to B.26

**B.25.a How often has this happened?**

1 = Once 3 = A lot 2 = A few times

-6 = Refused; -7 = DK; -8 = NA; -9 = Missing

**B.25.b How old were you when this (first) happened?**

1 = 0-5 yrs/before started school

2 = 6-10 yrs/middle

3 = 11-13 yrs middle/secondary school

4 = 14-17 yrs/secondary/upper school

5 = 18 yrs or older

6 = Refused; -7 = DK; -8 = NA; -9 = Missing

**B.25.c Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.26 Have you ever been strip searched, physically restrained, or secluded by police, nursing staff, or other providers.**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.27 Have you ever been discriminated against in a way that was highly distressing or disturbing? This could include discrimination due to race, ethnic group, gender, disability, age, weight, sexual orientation, illness, or religion?**

1 = Yes; 0 = No; -6 = Ref; -7 = DK; -8 = NA; -9 = Missing

If NO, skip to B.28

**B.27.a How often has this happened?**

1 = Once 2 = A few times 3 = A lot

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.27.b How old were you when this (first) happened?**

1 = 0-5 yrs/before started school

2 = 6-10 yrs/middle

3 = 11-13 yrs middle/secondary school

4 = 14-17 yrs/secondary/upper school

5 = 18 yrs or older

6 = Refused; -7 = DK; -8 = NA; -9 = Missing

**B.27.c Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.29 Have you ever been harassed by sexual remarks, jokes, groping, or demands for sexual favours?**

1 = Yes; 0 = No; -6 = Ref; -7 = DK; -8 = NA; -9 = Missing

If NO, skip to B.30

**B.29.a How often has this happened?**

1 = Once 2 = A few times 3 = A lot

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.29.b How old were you when this (first) happened?**

1 = 0-5 yrs/before started school

2 = 6-10 yrs/middle

3 = 11-13 yrs middle/secondary school

4 = 14-17 yrs/secondary/upper school

5 = 18 yrs or older

6 = Refused; -7 = DK; 8 = NA; 9 = Missing

**B.29.c Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.30 Were you ever touched or made to touch someone else in a sexual way, because you felt forced in some way or threatened by harm to yourself or someone else?**

1 = Yes; 0 = No; -6 = Ref; -7 = DK; -8 = NA; -9 = Missing

If NO, skip to B.31

**B.30.a How old were you when this (first) happened?**

1 = 0-5 yrs/before started school

2 = 6-10 yrs/middle

3 = 11-13 yrs middle/secondary school

4 = 14-17 yrs/secondary/upper school

5 = 18 yrs or older

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

If "18 years or older" skip to B.30.c

**Substitute Card #1 for Card #1a**

**B.30.b How often did this happen before age 18?**

0 = Never 1 = Once 2 = A few times 3 = A lot

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.30.c How often has this happened since you turned 18?**

0 = Never 1 = Once 2 = A few times 3 = A lot

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.30.d Has this happened in the past six months?**

1 = Yes; 0 = No; -6 = Ref; -7 = DK; -8 = NA; -9 = Missing

**B.31 Did someone ever have sex with you by force or threat of harm to yourself or someone else? For example this would include being molested or raped by a family member, someone you knew well, an acquaintance, or someone you did not know at all.**

1 = Yes; 0 = No; -6 = Ref; -7 = DK; -8 = NA; -9 = Missing

If NO, skip to B.32

**B.31.a How old were you when this (first) happened?**

1 = 0-5 yrs/before started school

2 = 6-10 yrs/middle

3 = 11-13 yrs middle/secondary school

4 = 14-17 yrs/secondary/upper school

5 = 18 yrs or older

6 = Refused; -7 = DK; -8 = NA; -9 = Missing

If "18 years or older" skip to B.31.c

**B.31.b How often did this happen before age 18?**

0 = Never 1 = Once 2 = A few times 3 = A lot

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.31.c How often has this happened since you turned 18?**

0 = Never 1 = Once 2 = A few times 3 = A lot

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.31.d Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**Replace Card #1a with Card #1**

**B.32 Have you ever had sex when you did not want to - in exchange for money, drugs or other material goods such as shelter or clothing?**

1 = Yes; 0 = No; -6 = Ref; -7 = DK; -8 = NA; -9 = Missing

If NO, skip to B.33

**B.32.a How often has this happened?**

1 = Once 2 = A few times 3 = A lot

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.32.b How old were you when this (first) happened?**

1 = 0-5 yrs/before started school

2 = 6-10 yrs/middle

3 = 11-13 yrs middle/secondary school

4 = 14-17 yrs/secondary/upper school

5 = 18 yrs or older

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.32.c Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.33 Have you ever been forced by someone to participate in prostitution or to have sex with another person?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

If NO, skip to B.34

**B.33.a How often has this happened?**

1 = Once 2 = A few times 3 = A lot

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.33.b How old were you when this (first) happened?**

1 = 0-5 yrs/before started school

2 = 6-10 yrs/middle

3 = 11-13 yrs middle/secondary school

4 = 14-17 yrs/secondary/upper school

5 = 18 yrs or older

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.33.c Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

**B.34 Are there any other upsetting or stressful events from across your lifetime that we did not include that you would like to mention?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

What was the event?

**B.34.a How often has this happened?**

1 = Once 2 = A few times 3 = A lot

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.34.b How old were you when this (first) happened?**

1 = 0-5 yrs/before started school

2 = 6-10 yrs/middle

3 = 11-13 yrs middle/secondary school

4 = 14-17 yrs/secondary/upper school

5 = 18 yrs or older

6 = Refused; 7 = DK; 8 = NA; 9 = Missing

**B.34.c Has this happened in the past six months?**

1 = Yes; 0 = No; 6 = Ref; 7 = DK; 8 = NA; 9 = Missing

N.B – ask if the participant is ok and if they would like to take a break, get a drink/cigarette etc

## **Appendix 23: Focus group topic guide**

### **1) Motivations for taking part**

#### **Example probes:**

- Explore motivations to taking part in the study

### **2) Groupwork experiences**

#### **Example probes:**

- Explore thoughts on whether the group met the core goals (present on flipchart):
  - ❖ *Safety as the overarching goal (helping clients attain safety in relationships, thinking, behaviour, and emotions);*
  - ❖ *Integrated treatment (working on both trauma and substance use at the same time);*
  - ❖ *A focus on ideals to counteract the loss of ideals in both trauma and problematic substance use.*
- Explore what participants liked and did not like about the intervention.
  - ❖ Session topics (Prompt explore topics participants felt particularly useful/not useful and how/why)
  - ❖ Handouts (Prompt: ease of understanding, language, usefulness within the session and outside)
  - ❖ Structure of the sessions (Prompt: check-in, discussion/handouts, check-out)
  - ❖ Commitments and community resources (Prompt: usefulness in promoting change behaviour)
  - ❖ General format (Prompt: pre-orientation, length of group, frequency, session length)
- Explore if participants used the handouts outside of the group and how. (Prompt: in 1:1 sessions)
- Explore if participants noticed any immediate changes in self since taking part in group

### **3) Group cohesion and therapeutic alliance**

#### **Example probes**

- Explore the group's thoughts on the facilitators (Prompt: skills, characteristics, values, being connected to them)
- Explore experiences of the wider group process

### **4) Facilitators/barriers**

#### **Example Probes**

- Explore experiences of assertive outreach (i.e. being reminded of sessions via text/phone-calls and being followed up by the facilitators between sessions)
- Explore feelings associated with missing sessions and barriers/facilitators to coming back

### **5) Future roll out**

#### **Example probes**

- Explore if there are any further recommendations for future role out.

## **Appendix 24: Semi-structured interview topic guide 1**

### **Participant interview schedule (T2)**

#### **1) Recovery**

##### **Example probes:**

- Explore general experiences of the group
- Identify any changes experienced by participants (in relation to 1) substance use, 2) psychological distress/PTSD, 3) safety)
- Explore participants' views on the impact of the session content and group process in relation to any changes described (e.g., since attending the group, how do you cope now with PTSD or substance use cravings/triggers? Are these different from before you attended the group? If so, why/ what did you learn?)
- Explore what aspects of group content/format participants found most/least helpful (open ended then followed by prompts for 1) Check-in, 2) Quote, 3) Handouts, 4). Discussions, 5) Learning coping strategies, 6) Commitments/Homework, 7) Check-out)
- Explore if there were external factors (during the group or in the last few months since finishing groups) influencing participants' abilities to implement the coping skills taught in the sessions or influencing the changes they saw in themselves.
- Explore views of the facilitators – group process

#### **2) Safety (For women reporting ongoing victimisation post-baseline)**

##### **Example probes:**

- Explore participants' experiences of the safety content of the intervention. Probe for any safety strategies they learnt and implemented
- Explore any other safety strategies/information learned by participants outside of the intervention
- Explore any barriers/facilitators to participants implementing any learning around safety.

#### **3) Attendance (for those attending <50% sessions)**

##### **Example probes**

- Explore participants' reasons for choosing to attend or not attend specific sessions
- Explore facilitators/barriers to attendance at the group
- Explore if anything could have been done to encourage participants' to re-attend.

## **Appendix 25: Semi-structured interview topic guide 2**

### **1) Research process**

*Example probes:*

- Explore facilitators' motivations for taking part in the study.
- Explore facilitators' expectations for the intervention.
- Explore facilitators' views on the adaptation stages of intervention.
- Explore facilitators' views of the recruitment process.
- Explore facilitators' experiences with the fidelity assessment of the intervention.

### **2) Experience of the intervention model:**

*Example probes:*

- Explore if/how the Seeking Safety intervention differed from other groupwork programmes they have delivered.
- Explore what the facilitators liked and did not like about the intervention. (Prompt: session content, handouts, format etc.)
- Explore what sessions they felt were particularly useful.
- Explore any things in the intervention they would change/adapt.

### **3) Experience of group delivery:**

*Example probes:*

- Explore facilitators' experience of co-delivery of the group.
- Explore facilitators' views about the dynamics in the group e.g. what worked well/didn't work well.
- Explore facilitators' views any particular characteristics of women who engaged well/less well with the 1) group 2) materials 3) homework practice.
- Explore facilitators' experience of supporting women at different stages of recovery in the groups.
- Explore if there were circumstances where intensive support was provided to participants outside of the group (in terms of safety, mental health housing or other issues.)
- Explore if there were any circumstances of covering the material from the group in 1:1 sessions.

### **4) Support and organisational issues**

*Example probes:*

- Explore facilitators' experience of receiving training to deliver the group and the preparation time provided.
- Explore facilitators' experience of clinical supervision.
- Explore facilitators' experience of organisational resources provided for the intervention.



- Explore facilitators experience of the organisational culture and how this is complementary/discordant of the principles of the trauma-focused philosophy of the intervention.

#### **5) Future roll out**

*Example probes:*

- Explore facilitators views about future roll-outs of the programme.

## **Appendix 26: Semi-structured interview topic guide (Service Manager)**

### **Experiences of participating in the study**

- What was your motivation for being part of this study?
- What were your general experiences of taking part in this study?
- What were your opinions about the resources required to deliver the programme (i.e. staff time)
- Do you feel the staff time allocated was suitable? Met your expectations?
- Do you have any thoughts about the preparation and training provided to Eliana and other staff? Was it sufficient?
- How did the loss of contract and subsequent service closure impact on the ability to deliver the group?

### **Trauma informed practice**

When we spoke before, I know you were keen to take the service through the process of developing trauma informed practice.

- Where would you say the service us in terms of fully developing an organisational approach to trauma informed practice?
- What do you think it did well?
- Where do you think more work was needed?
- How do you think TIP was instigated at the management level?
- How was it instigated at the practice level?
- How was it featuring in the assessment and care plans
- Staff training, hiring practices
- How do you think service user choice, and involvement featured in the service?

## Appendix 27: Initial ‘framework’ developed in the early stages of qualitative data management

<p><b>1. Research process</b></p> <p>1.1 Motivations for taking part</p> <p>1.3. Recruitment</p> <p>1.4. Assessments</p> <p>1.5 Programme review</p> <p>1.6 Facilitator preparation/training</p> <p>1.7 Fidelity process</p> <p>1.8 Facilitator supervision/support</p> <p>1.9 Facilitator skills/experience</p> <p><b>2. Session structure</b></p> <p>2.1. Check-in</p> <p>2.2. Quotations</p> <p>2.3. Discussion</p> <p>2.4 Commitments</p> <p>2.5 Check-out</p> <p>2.6 Hand-outs</p> <p><b>3. Programme format</b></p> <p>3.1 Group size</p> <p>3.2 Session length</p> <p>3.3 Session frequency</p> <p>3.4 Views on topics</p> <p><b>4. Attendance</b></p> <p>4.1 Barriers</p> <p>4.2 Reasons for missing sessions</p> <p>4.3 Impact of missed sessions</p> <p>4.4 Follow up after missed sessions</p> <p>4.5 Session reminders</p> <p>4.6 Flexibility</p> <p><b>5. Experience of the group</b></p> <p>5.1 General</p> <p>5.2 Things liked/helpful</p> <p>5.3 Things disliked/unhelpful</p> <p>5.4 Skills learnt</p> <p>5.5 Being ready</p> <p>5.6 Group dynamic</p> <p>5.7 Therapeutic Alliance</p> <p>5.8 Emotional responses during sessions</p> <p>5.9 Learning process</p>	<p><b>6. Changes experienced</b></p> <p>6.1 Emotional wellbeing</p> <p>6.2 Thinking</p> <p>6.3 Self-esteem</p> <p>6.4 Identifying abuse</p> <p>6.5 Keeping Safe</p> <p>6.6 Boundaries</p> <p><b>7. External influences</b></p> <p>7.1 Service environment</p> <p>7.2 One to one support</p> <p>7.3 Keyworker responses</p> <p>7.4 Service closure</p> <p>7.5 Other interventions</p> <p>7.6 Trauma informed care</p> <p>7.7. Social support</p> <p>7.8 Ongoing abuse</p> <p>7.9 Family</p> <p>7.10 Work</p> <p>7.11 Problems with other services</p> <p><b>8. Health</b></p> <p>8.1 Causes of relapse</p> <p>8.2 Physical health</p> <p>8.3 Co-occurring mental health problems</p> <p>8.4 Medication</p> <p>8.5 Exercise</p>
--	---

## Appendix 28: 'Abstraction and Interpretation Stage' of qualitative data analysis

Excerpt from development of Detected Elements and Key Dimensions from the initial theme of 'Research Process'

This table outlines an early stage of data analysis where summarised data is grouped together under key dimensions. (\* Participant ID, group dose, PTSD change at T2 and/or T3)

1. Research Process- Detected Elements	Key Dimensions
<b>1.1 Assessments</b>	
~Generally positive experience (T301_10, >50, T3PTSDY)* ~Good experience(T301_09, >50, T2PTSDY, T3PTSDY) ~Assessments were alright(T301_19, >50, T2PTSDY, T3PTSDY) ~Assessments were fine(T301_20, >50, T2PTSDN, T3PTSDY) ~Glad to be able to do something positive and contribute to the study(T301_18, >50, T2PTSDN, T3PTSDN) ~Assessments were fine (T302_04, >50. T2PTSDY, T3PTSDN)	Positive response to assessments -
~Gained confidence in doing them since the group(T301_20, >50, T2PTSDN, T3PTSDY) ~Felt she was in a better place at T3 and assessments were more manageable and easier than previous ones(T301_15, <50, T2PTSD, T3PTSD) ~Realised she was in a different mind frame in terms of how she is coping(T301_15, <50, T2PTSD, T3PTSD) ~Answering more positively(T301_15, <50, T2PTSD, T3PTSD) ~Felt stronger and more confident at each assessment because of the group(T202_03, >50, T2PTSDY, T3PTSDY)	Positive continued assessment highlighted improvements -
~No need for support after (T301_15, <50, T2PTSD, T3PTSD) ~ Did not need to speak to anyone after (T301_18, >50, T2PTSDN, T3PTSDN) ~No need to seek support after (T302_04, >50. T2PTSDY, T3PTSDN) ~Knew there was support there if she needed it (T202_03, >50, T2PTSDY, T3PTSDY) ~Didn't feel need to go and use afterwards(T301_10, >50, T3PTSDY) ~Didn't feel the need to use afterwards(T202_03, >50, T2PTSDY, T3PTSDY) ~ Not distressing(T301_09, >50, T2PTSDY, T3PTSDY) ~Felt comfortable talking about the subject(01_02, <50, T2PTSDY, T3PTSDY) ~Felt free and open to talk(T302_04, >50. T2PTSDY, T3PTSDN) ~Would not have taken part in the study if she wasn't feeling that way(T302_04, >50. T2PTSDY, T3PTSDN) ~Kept mind logical in order that emotions did not get in the way(T301_18, >50, T2PTSDN, T3PTSDN)	Positive assessment did not increase need for support -
~Had an emotional breakdown after the T2 assessment linked to current mental health state(T301_20, >50, T2PTSDN, T3PTSDY) ~ Distressing to be asked how many times she thought about the abuse(T301_10, >50, T3PTSDY) ~Found it all distressing(T301_18, >50, T2PTSDN, T3PTSDN) ~Brought back memories(01_02, <50, T2PTSDY, T3PTSDY) ~Felt anxious(T202_03, >50, T2PTSDY, T3PTSDY) ~Made her remember things and take her back to places(T202_03, >50, T2PTSDY, T3PTSDY) ~Made her feel a bit down(T302_29, <50, T2PTSDY, T3PTSDY)	Negative emotional responses to assessments -
~ Some questions complicated(T301_10, >50, T3PTSDY) ~Found it hard to rate what others may think of her skills and capabilities because she doesn't socialise much nor have a best friend(T301_10, >50, T3PTSDY) ~Different forms of agree/disagree were confusing(T301_10, >50, T3PTSDY)	Negative - clarity of question items

<p>~Qs with dichotomous answers yes/not were confusing(T301_19, &gt;50, T2PTSDY, T3PTSDY)</p> <p>~Clear language(T301_15, &lt;50, T2PTSD, T3PTSD)</p> <p>~Found some of the Qs similar but not confusing(T302_04, &gt;50, T2PTSDY, T3PTSDN)</p> <p>~Found post-trauma cognitions Qs difficult to answer(T302_25, &gt;50, T2PTSDN, T3PTSDN)</p> <p>~Felt she was a bit in-between answers (T302_25, &gt;50, T2PTSDN, T3PTSDN)</p> <p>~Felt answers were influenced by what had happened that week(T301_19, &gt;50, T2PTSDY, T3PTSDY)</p> <p>~Would have answered differently last week as feeling different(T301_19, &gt;50, T2PTSDY, T3PTSDY)</p> <p>~Depends on the particular day(T302_25, &gt;50, T2PTSDN, T3PTSDN)</p> <p>~On a bad day feels more negative about herself(T302_25, &gt;50, T2PTSDN, T3PTSDN)</p> <p>~If she were feeling more positive she may have answered differently(T302_29, &lt;50, T2PTSDY, T3PTSDY)</p> <p>~Believed the correct things being measured(T301_10, &gt;50, T3PTSDY)</p> <p>~Felt all measure were relevant (T301_18, &gt;50, T2PTSDN, T3PTSDN)</p> <p>~List of coping skills was comprehensive (T301_15, &lt;50, T2PTSD, T3PTSD)</p> <p>~Thought list of coping skills covered everything(T202_03, &gt;50, T2PTSDY, T3PTSDY)</p> <p>~Suggested assessing awareness of environment and nature (T301_10, &gt;50, T3PTSDY)</p> <p>~Major thing is depression (T301_18, &gt;50, T2PTSDN, T3PTSDN)</p> <p>~Suggested measures for help seeking with mental health professional or GP, general mood(T302_29, &lt;50, T2PTSDY, T3PTSDY)</p>	<p>Negative - impact of changing nature of mood on answering questions</p> <p>Positive relevance of measures - of</p>
---	---

## Appendix 29: Summary of ‘Detected Elements and Key Dimensions’ in qualitative data analysis

This table summarises all ‘key dimensions’ identified for each of the 7 over-arching themes (and sub-themes) defined in the initial framework as part of the Abstraction and Interpretation Stage.’

<b>1. Research Process</b>	
	<b>Key Dimensions</b>
1.1 Assessments	<ul style="list-style-type: none"> <li>• Positive - response to assessments</li> <li>• Positive – continued assessment highlighted improvements</li> <li>• Positive – assessment did not increase need for support</li> <li>• Negative - emotional responses to assessments</li> <li>• Negative - Clarity of question items</li> <li>• Negative - Impact of changing nature of mood on answering questions</li> <li>• Positive -Relevance of measures</li> </ul>
1.2 Programme Review (staff data only)	<ul style="list-style-type: none"> <li>• Understanding of need for material review</li> <li>• Resource intensive</li> <li>• Distraction from delivery preparation</li> </ul>
1.3 Facilitator Preparation (staff data only)	<ul style="list-style-type: none"> <li>• More time needed for preparation</li> <li>• Felt overwhelmed /anxious</li> <li>• Inadequate training</li> <li>• Lack of clarity of research process</li> </ul>
1.4 Fidelity Process (staff data only)	<ul style="list-style-type: none"> <li>• Negative reactions to fidelity process</li> <li>• Face to face feedback mechanisms required</li> <li>• Mismatch between feedback and requirements of the group</li> </ul>
1.5 Facilitator support (staff data only)	<ul style="list-style-type: none"> <li>• Personal issues</li> <li>• Insufficient clinical supervision</li> <li>• Workload management</li> <li>• Lack of support from colleagues</li> <li>• Service environment unwelcoming</li> </ul>
1.6 Facilitator – skills and experience (staff data only)	<ul style="list-style-type: none"> <li>• Required characteristics/strengths/skills for facilitators</li> <li>• Knowledge of topics</li> <li>• Learning curve</li> </ul>
<b>2. Session Structure</b>	
	<b>Key Dimensions</b>
2.1 Check-in	<ul style="list-style-type: none"> <li>• Positive – shorter check-in</li> <li>• Negative – ability to express oneself</li> </ul>
2.2 Quotations	<ul style="list-style-type: none"> <li>• Positive – meaningful</li> <li>• Positive – hearing other’s insights</li> </ul>
2.3 Discussion	<ul style="list-style-type: none"> <li>• Negative - lack of time</li> <li>• Positive – enjoyed exercises</li> </ul>
2.4 Commitments	<ul style="list-style-type: none"> <li>• Positive - motivated action</li> <li>• Positive - goal setting/planning</li> <li>• Positive - encouragement not enforcement</li> <li>• Negative - relevance of commitments</li> <li>• Negative - remembering to do commitments</li> </ul>

	<ul style="list-style-type: none"> <li>Negative - challenging to stick to commitments</li> <li>Suggested adaptations for commitments</li> </ul>
2.5 Check-out	<ul style="list-style-type: none"> <li>Positive -reflection space</li> <li>Negative - difficult</li> <li>Suggested adaptations for check-out</li> </ul>
2.6 Handouts	<ul style="list-style-type: none"> <li>Use of handouts outside of the sessions</li> <li>Negative - pace of using handouts too fast</li> <li>Positive - acceptable language</li> <li>Suggestions - Reading out loud</li> </ul>
2.7 Case Management	<ul style="list-style-type: none"> <li>Positive - support and guidance from staff</li> <li>Positive - Additional 1:1 support from facilitators</li> <li>Negative - lack of support from keyworkers</li> </ul>
<b>3. Programme Format</b>	
	<b>Key Dimensions</b>
3.1 Group Size	<ul style="list-style-type: none"> <li>Smaller group size important</li> </ul>
3.2 Session Length	<ul style="list-style-type: none"> <li>Negative - not enough time</li> <li>Support for longer sessions</li> <li>Support for current session length</li> </ul>
3.3 Session Frequency	<ul style="list-style-type: none"> <li>Support for twice weekly sessions</li> <li>Extend group beyond 6 weeks</li> </ul>
3.4 Subject matter	<ul style="list-style-type: none"> <li>Subject matter experienced as intense</li> <li>Positive - specific topics</li> <li>Positive - relevance of topics</li> <li>Negative – less relevant for substance use</li> <li>Support for splitting topics over sessions</li> <li>Preference for one topic per session</li> <li>General suggested adaptations</li> </ul>

<b>4. Attendance</b>	
	<b>Key Dimensions</b>
4.1 Missed sessions	<ul style="list-style-type: none"> <li>Other priorities</li> <li>Start time too early</li> <li><u>Linked to service closure</u></li> <li>Relapse</li> <li>Emotional impact of group</li> <li>Feeling isolated from group</li> <li>Regrets for missed sessions</li> <li>Impact of inconsistent attendance on others</li> </ul>
4.2 Session reminders	<ul style="list-style-type: none"> <li>Positive - appreciated</li> <li>Negative - unnecessary</li> </ul>
<b>5. Experience of the group</b>	
	<b>Key Dimensions</b>
5.1 Motivations for taking part	<ul style="list-style-type: none"> <li>To understand about trauma and PTSD</li> <li>To understand about links between trauma/ PTSD and substance use</li> <li>To understand own behaviour</li> <li>Acknowledgement of need for change</li> <li>Staff recommendation</li> </ul>
5.2 Additional support	<ul style="list-style-type: none"> <li>1:1 support needed after the group</li> <li>Follow-on support needed</li> <li><u>Linked to service closure</u></li> <li>Group has encouraged more help-seeking</li> </ul>
5.3 Group Dynamic	<ul style="list-style-type: none"> <li>Positive - Group support</li> <li>Negative - not fitting in</li> <li>Negative – unable to express oneself</li> <li>Positive -women only</li> </ul>

	<ul style="list-style-type: none"> <li>• Positive- women like us</li> <li>• Positive - hearing from others</li> <li>• Negative - confidentiality concerns</li> <li>• Negative - disruptive presence of others</li> <li>• <u>Dynamic between those who are in Abstinence and Stabilisation groups</u></li> <li>• <u>Negative - Unfair treatment of some participants</u></li> <li>• <u>Negative - prior relationship with other participants</u></li> </ul>
5.4 Liked/helpful	<ul style="list-style-type: none"> <li>• Grounding – use of sensory tools</li> <li>• Structured format</li> <li>• Not peer led</li> <li>• Limited trauma discussion</li> <li>• Different to other groups</li> <li>• Gave hope for the future</li> </ul>
5.5 Things disliked	<ul style="list-style-type: none"> <li>• Triggering traumatic memories</li> <li>• Feeling shut down</li> <li>• Not enough time to talk</li> <li>• Felt rushed</li> <li>• Drug use accusation</li> <li>• Limited trauma discussion</li> </ul>
5.6 Skills learnt	<ul style="list-style-type: none"> <li>• Alternative ways of coping</li> <li>• Acknowledging the problem</li> <li>• Being mindful</li> <li>• Increased emotional awareness</li> <li>• Dealing with/Awareness of anger</li> <li>• Grounding</li> <li>• Self-care</li> </ul>
5.7 Being ready	<ul style="list-style-type: none"> <li>• Struggling with change</li> <li>• Challenges due to active substance use</li> <li>• Readiness for engagement</li> </ul>
5.8 Views on the facilitators	<ul style="list-style-type: none"> <li>• Positive experience of facilitators</li> <li>• Tensions with facilitators</li> <li>• Less familiar with external facilitator</li> <li>• Awareness of facilitators' dilemma</li> </ul>
5.9 Learning process	<ul style="list-style-type: none"> <li>• Work in progress</li> <li>• Time needed to process learning</li> <li>• Amalgamating learning from different sources</li> <li>• Reinforcement and practice needed</li> </ul>
5.10 Emotional response during sessions	<ul style="list-style-type: none"> <li>• Intense subject matter</li> <li>• Triggering of memories by others in the group</li> <li>• Worsening PTSD symptoms</li> <li>• Substance cravings</li> </ul>
<b>6. Changes</b>	
	<b>Key Dimensions</b>
6.1 Emotional wellbeing	<ul style="list-style-type: none"> <li>• Improved mental health</li> <li>• Less guilt and shame</li> <li>• Better emotional management</li> </ul>
6.2 Cognitions	<ul style="list-style-type: none"> <li>• Clearer thought processes</li> <li>• Managing negative self-talk</li> <li>• Planning ahead</li> <li>• Taking time to think</li> <li>• Positive thinking</li> <li>• Self-compassion</li> </ul>
6.3 Self-Esteem	<ul style="list-style-type: none"> <li>• Increased self belief/worth</li> <li>• Recognising rights</li> <li>• Self-esteem protective against self-harm</li> <li>• Empowerment</li> <li>• Now more assertive</li> </ul>
6.4 Keeping safe	<ul style="list-style-type: none"> <li>• Identifying abuse</li> <li>• Protecting against emotional abuse from family members</li> <li>• Protecting against emotional abuse from a stranger</li> </ul>



6.5 Relationships	<ul style="list-style-type: none"> <li>• Avoiding unhealthy intimate relationships</li> <li>• Improved relations with family members</li> <li>• More strained family relationships as a result of completing the group</li> <li>• Avoiding unfulfilling and unhealthy friendships</li> </ul>
6.6 Substance use	<ul style="list-style-type: none"> <li>• Group supporting maintained sobriety</li> <li>• Group made substance cravings worse</li> <li>• Reasons for return to active substance use</li> </ul>
<b>7. Contextual factors</b>	
7.1 Service environment	<ul style="list-style-type: none"> <li>• Positive - more than a treatment service</li> <li>• Positive – evidence for some components of trauma informed care</li> <li>• Positive – expressive therapies complimentary to the group</li> <li>• Positive- other support groups useful</li> <li>• Negative – practice running counter to trauma informed care</li> <li>• Negative - predatory male clients</li> <li>• Negative - lack of childcare</li> <li>• Negative – views of other groups</li> </ul>
7.2 Service closure	<ul style="list-style-type: none"> <li>• Relapse due to service closure</li> <li>• Lack of support following closure</li> <li>• Negative perceptions of new service</li> </ul>
7.3 Social Support	<ul style="list-style-type: none"> <li>• Family support</li> <li>• Improved social network</li> <li>• Negative impact of friends</li> <li>• Poor social network</li> </ul>
7.4 On-going abuse	<ul style="list-style-type: none"> <li>• Abuse from strangers</li> <li>• Abuse from family members</li> <li>• Abuse from ex-partners</li> <li>• Abuse from associates</li> </ul>
7.5 Family pressures	<ul style="list-style-type: none"> <li>• Childcare pressures – young children</li> <li>• On-going stressors- older children</li> <li>• <u>Separated from children - social services involvement</u></li> </ul>
7.6 Health concerns	<ul style="list-style-type: none"> <li>• Depression as a barrier to use of coping skills</li> <li>• Other on-going mental health challenges</li> </ul>
7.7 Other enablers or barriers to recovery	<ul style="list-style-type: none"> <li>• Negative - unstable housing</li> <li>• Positive - work</li> </ul>

## Appendix 30: Themes identified in the final stage of qualitative analysis.

This table summarises the final set of over-arching themes and sub-themes produced at the end of the analysis, with descriptions of any participant attributes that influenced the themes (marked \*) and the linkage with quantitative data as part of the mixed methods analysis. These are presented under the headings corresponding to the results sections in Chapter 7 and 8.

### 1. Recruitment and feasibility parameters

Qualitative		Linkage with other data
Theme	Sub-themes	Other data
<b>Motivations for taking part</b>		
	Self-understanding	CONSORT flowchart
	Staff encouragement	Attendance rates
		Retention rates (group/study)
		Researcher field-notes
<b>Missed sessions</b>		
<i>Attendance ≥ 6* sessions</i>	Competing priorities	
<i>Attendance &lt; 6 sessions*</i>	Relapse	
	Emotional intensity	
	Regret	
<b>Suitability and acceptability of study measures</b>		
	Opportunity for reflection	Researcher field-notes
	Distress	
	Relevance and clarity of questionnaires	

## 2. Implementation: staff perceptions (interview data from group facilitators and Service manager)

Qualitative		Linkage with other data
Themes	Sub-themes	Other data
<b>Programme material review and adaptation</b>		
	Resource intensive	
	Lack of preparation time	
	Inadequate facilitator training	
<b>Monitoring for fidelity to intervention model</b>		
	Unexpected roles imposed on facilitators	Seeking Safety Adherence Scale
	Ineffective feedback mechanisms	Researcher field-notes
	Requirements of intervention adherence incongruent with group realities	Notes of meetings with intervention author
<b>Support mechanisms</b>		
	Sufficiency of clinical supervision	
	Workload management	
	Peer support	
<b>Facilitator qualities and skills</b>		
	Personal strengths	Researcher field-notes
	Knowledge of group process, PTSD and substance use	
<b>Views on the programme</b>		
	Overall support for the intervention	
	Negative views on intervention components	

### 3. Implementation: acceptability of the intervention by the group participants

Qualitative		Linkage with other data	
Themes	Sub-themes	Quantitative measures	Other data
<b>Subject matter</b>			
	Intensity		Session questionnaires
	Relevance		
	Value of sensory-based activities		
<b>Group Dynamic</b>			
<i>Across all attributes*</i>	Bonding through shared experiences	Measures of group cohesion (CALPAS-G)	
	Hearing from others		
	Peer support		
	Feeling shut down		
	Tensions between women in different stages of recovery		
<i>Attendance ≥ 6 sessions in Group 2*</i>	Frustrations with others		
<b>Therapeutic Alliance</b>			
<i>Attendance ≥ 6 sessions</i>	Positive experience of facilitators	Working Alliance Inventory – Short Form (WAI-SF)	
<i>Across all attributes</i>	Growing pains		
<b>General Format</b>			
<i>Across all attributes*</i>	Unsuitable session pace		Seeking Safety Feedback Questionnaire
	Slowing down the pace: lengthier intervention		
<i>Attendance ≥ 6 sessions*</i>	Unique group experience		
	Limited trauma discussion		

	One to one support from facilitators		
<b>Structural components</b>			
	Support for shorter check-ins		Seeking Safety Feedback Questionnaire
	Expressing feelings		
	Positive reaction to quotes		
	Commitments were encouraged not enforced		
	Commitments motivated action		
	Challenges to implementation of commitments		
	Accessibility of handouts		
	Reading and concentration		

#### 4. Implementation: changes experienced by group participants

Qualitative		Linkage with other data	
Theme	Sub-themes	Quantitative measures	Other data
Alternative ways of coping			
Across all attributes*	Mind-body strategies	Coping Skills (Coping Skills Questionnaire).	
	Behavioural strategies		
Group 1 only*	Cognitive based strategies		
Emotional wellbeing			
Improvement in PTSD*	Improved PTSD symptoms	PTSD (PCL-5); Depression (PHQ-9); Emotional Regulation (DERS-SF);	
Attendance ≥ 6 sessions	Improved Emotional management		
	Using self-compassion and mindfulness		
	Enhanced self-esteem	Self-Esteem (Rosenberg Self-Esteem Scale);	
Emotional challenges of the group			
	Negative impact on PTSD during the programme		
	Feeling shut down (cross reference with Group Dynamic)		
Changes in substance use			
	Mixed group impact on substance use		
	Self-understanding: linking substance use and trauma		
	Relapse at follow up	Drugs and Alcohol (ASI-Composite Scores, Days use in past 30 days);	
Relationships with others			

Attendance ≥ 6 sessions	Assertiveness		
Group 2 only	Identifying unhealthy behaviours in others		
PTSD deterioration*	Negative impact on family relationships		

## 5. Contextual factors influencing intervention delivery and outcomes

Qualitative		Linkage with other data	
Themes	Sub-themes	Quantitative measures	Other data
<b>Internal factors: individuals' characteristics</b>			
	Being in the right headspace		
	Co-occurring mental health challenges	Depression (PHQ-9)	
<b>External factors: service environment</b>			
	Re-enforcement and practice of coping skills		Service receipt inventory
	Inconsistent access to key-work and counselling		
	Negative impact of service closure		
	Trauma informed practice		
<b>External factors: ongoing exposure to stress</b>			
	Stressful relationships		
	Experiences of IPA during the group	WCDV Life Stressor Checklist-R	
	Experiences of IPA during the 3 month follow up	Composite Abuse Scale-SF	

## Appendix 31: Confirmation of ethics approval for the feasibility study from Kings College London

Research Ethics  
Office

Franklin Wilkins Building  
5.9 Waterloo Bridge Wing  
Waterloo Road  
London SE1 9NH  
Telephone 020 7848 4020/4070/4077  
rec@kcl.ac.uk



Karen Bailey

14 June 2017

Dear Karen,

Study Title: Feasibility study for Seeking Safety group work programme

Study Reference:HR-16/17-4598

I am pleased to inform you that full approval for your project has been granted by the PNM Research Ethics Subcommittee .

For your information, ethical approval has been granted for 3 years from 14 June 2017. If you need approval beyond this point, you will need to apply for an extension at least two weeks before this. You will be required to explain the reasons for the extension. However, you will not need to submit a full re-application unless the protocol has changed.

Ethical approval is required to cover the data-collection phase of the study. This will be until the date specified in this letter. However, you do not need ethical approval to cover subsequent data analysis or publication of the results. For secondary data-analysis, ethical approval is applicable to the data that is sensitive or identifies participants.

Please ensure that you follow the guidelines for good research practice as laid out in UKRIO's Code of Practice for research:  
<http://www.kcl.ac.uk/innovation/research/support/conduct/cop/index.aspx>

Please note you are required to adhere to all research data/records management and storage procedures agreed to as part of your application. This will be expected even after the completion of the study.

If you do not start the project within three months of this letter, please contact the Research Ethics Office.

Please note that you will be required to obtain approval to modify the study. This also encompasses extensions to periods of approval. Please refer to the URL below for further guidance about the process:

<http://www.kcl.ac.uk/innovation/research/support/ethics/applications/modifications.aspx>

Please would you also note that we may, for the purposes of audit, contact you from time to time to ascertain the status of your research.

If you have any query about any aspect of this ethical approval, please contact the Research Ethics Office:

(<http://www.kcl.ac.uk/innovation/research/support/ethics/contact.aspx>)

We wish you every success with this work.

Yours sincerely,

Mr James Patterson  
Senior Research Ethics Officer

**For and on behalf of**

Mr Chris Webb, Acting Chair of the PNM Research Ethics Subcommittee



## **Appendix 32: Researcher Safety Protocol**

(Procedures for safe communication with study participants and maintaining researcher well-being)

The following procedures were taken from the Standard Operating Protocol for domestic violence victims established by the Section of Women's Mental Health at King's College London.

When telephone calls were made to study participants the following steps were taken:

- The identity of the caller was established before providing any description of the study, to ensure the protection of the participant;
- The participant was asked if they were currently in a safe environment to speak. Participants were told they should not put themselves at any risk by participating in the study;
- Where the participant wanted to keep their participation in the research confidential from others, a conversation would have taken place on how to manage the situation if conversations were overheard;
- At the first contact the participant was asked to specify their preferred method and time of contact for future communication, including times when it is safe or unsafe to contact them, and how they will indicate this to you. A record of this information was logged along with the participant's contact preferences;
- Any clinical queries arising from any forms of telephone contact with the participant were discussed with my supervisor (Gail Gilchrist) to determine if the nominated practitioner at the substance use treatment service should be alerted. This happened on one occasion, which resulted in the substance use staff member being alerted and further contact made with the participant to assure safety.

The following steps were taken when undertaking face-to-face interviews with study participants:

- No written and/or verbal information regarding sources of support was given to participants when they were in the presence of partners, family members, friends or children of comprehending age;
- Participants were asked whether it was safe for them to take away written information about sources of support;
- After each meeting, all participants were asked how they felt and if they would like to discuss anything further with a staff member. A short information leaflet of support services relating to domestic and sexual violence was made available at all face to face meetings with participants, with the safety caveat above.

### **Researcher Safety**

The following procedures were put in place to ensure the safety and wellbeing of those conducting interviews:

- Staff at the participating substance use treatment service were made aware of the interview schedule and whereabouts;
- A work mobile number rather than a personal mobile number was given to potential participants;
- Only work email addresses were used to correspond with participants;
- Debriefing/supervision for the researcher was available from a supervisor;
- Access to individual and group clinical supervision was provided.

### Appendix 33: CALPAS sub-scale scores

(disaggregated by group and dose\*)

	Total group (n=18)** [mean (SD)]	Group 1 (n=10)	Group 2 (n=8)*	=> 6 sessions (n=13)*	<6 sessions (n=5)
<b>a. Patient Working Capacity</b>	4.41 (1.65)	3.97 (1.83)	4.96 (1.28)	4.15(1.74)	5.07(1.32)
<b>b. Patient Commitment</b>	5.95 (1.19)	6.03 (1.06)	5.84 (1.40)	5.95(1.32)	5.93(0.90)
<b>c. Working Strategy Consensus</b>	5.08 (1.40)	5.00 (1.76)	5.17 (0.85)	5.28(1.23)	4.54(1.81)
<b>d. Member Understanding and Involvement</b>	5.55 (1.24)	5.60 (1.41)	5.48 (1.08)	5.81 (1.08)	4.87(2.67)

\*no statistical evidence for difference in any of the scores between Group 1/Group 2, and session dose

\*\* missing data from one participant

## Appendix 34: Qualitative feedback for the Seeking Safety group components

Component	Score	Qualitative
<b>Check-in/Checkout</b>	2.38	<p><b>Support for short check-ins</b>  <i>In this group study, we had to keep it short and simple because we had something to be talking about.</i> (Beth, Group 1, 8 sessions PTSD improvement T2 &amp; T3).  <i>"They were quite good in that they cut it quite short, because I know in other things, I've been in groups here everyone has checked in and it's gone on."</i> (FG_Rachel, Group 2, Group1, 3 sessions, PTSD improvement T2 &amp; T3))</p>
<b>Quotations</b>	2.75	<p><b>Positive reaction to quotes</b>  <i>"I like the quotes I find them really helpful, it's nice to have something to take away with you even, it makes you think."</i> (FG_Rachel, Group 1, 3 sessions, PTSD improvement T2 &amp; T3)</p>
<b>Commitments</b>	2.50	<p><b>Encouragement not enforcement</b>  <i>"...the good thing about the commitment was there was absolutely not pressure to have to do it... you were not made to feel in any kind of way, if for whatever reason, you didn't do it. I found that more encouraging rather than them telling you."</i> (FG_Clare, Group 1, 12 sessions, PTSD improvement T2 &amp; T3)</p> <p><b>Motivated action</b>  <i>"It was good as it was something I need to do, sometimes I feel lazy, I don't want to do, but I have commitment and I need to do to prove myself, not because of group. I prove to me that I need to do this."</i> (Gloria, Group 1, 11 sessions, PTSD improvement T2 &amp; T3)</p> <p><i>"But it was just good cause it made me think when I went home, I've got to do this, so it kept me, it motivated me to do it."</i> (FG_Jasmine, Group 2, 12 sessions, No PTSD improvement)</p> <p><b>Challenges to implementation</b>  <i>"I think in a way sometimes with me, sometimes I couldn't do my commitment. So if we were able to do a commitment Monday to Thursday and then recommit to doing it Thursday to Monday."</i> (FG_Jamila, Group 1, 7 sessions, PTSD improvement T3)  <i>"...when you go back home you forget and you just carry on your day to day."</i> (Neesha, Group 2, 7 sessions, no PTSD improvement)</p>
<b>Hand-outs</b>	2.83	<p><b>Accessibility of handouts</b>  <i>"I thought they was really good, really insightful, really helpful and really understandable."</i> (Steph, Group 2, 9 sessions, PTSD improvement T&amp;T3)</p> <p><i>'...there were a couple of things , wording I mean. I didn't mark them that low but there were a few things, but I cant think now.'</i> (FG_Gina, Group 2, 8 sessions, PTSD improvement T2)</p> <p><i>"There was one week where it was asking us questions and it was like it was the American way of the double negative, which is very confusing, that was the only time I was thinking I don't know what the hell they are asking me here."</i> (FG_Tara, Group 1, 12 sessions, PTSD improvement T2 &amp; T3)</p>

		<p><b>Helpful outside of sessions</b>  <i>"Yeah I have them at home, yeah always I read something and even my grandson, some words I don't understand, he has very good English, and I learn what means this, and I showed him."</i> (Gloria, Group 1, 11 sessions, PTSD change T2&amp;T3)</p> <p><b>Unhelpful outside of sessions</b>  <i>"I don't want to get overloaded, because even though everything I am doing is positive, it is a constant reminder that am ill, if you know what I mean, mentally, something is wrong, and sometimes, I just want to put them away."</i> (Sophie, Group 1, 11 sessions, No PTSD improvement)</p> <p><b>Reading and concentration</b>  <i>Focus Group extract</i>  <i>Jasmine: I was conscious that I had read it and some people hadn't and some people were waiting for me, but I don't know, if someone had read it out if I would have listened more, I don't know.</i>  <i>Gina: I think I would have taken it in more.</i>  <i>Steph: I would have taken it in more also.</i></p>
--	--	--

\* Based on 14 programme questionnaires completed at the final session

## Appendix 35: Summary and non-parametric test statistics for study measures

\* Wilcoxon Signed Rank tests with Bonferroni correction applied for multiple testing

Variable (median, range)	T1	T2	T3	Friedman test [ $\chi^2$ (df)]	T1-T2*	T1-T3*	T2-T3*
Trauma cognitions (PTCI-9)	5.22(2.56-6)	3.67(1.22-6.11)	2.78(1.11-6.11)	$\chi^2$ (2)=37.312, p=0.005	Z=2.64, p=<0.008	Z=2.277 p=0.023	Z= -10.80, p=0.427
ASI-Alcohol	0.04 (0.00-0.84)	0.00(0.00-0.69)	0.01(0.00-0.81)	$\chi^2$ (2)=28.816, p=0.051	Z=2.50, p=0.012	Z=1.098, p=0.272	Z=-0.706, p=0.480
Days of alcohol use (to intoxication) in past 30	0.00 (0-30)	0.00(0-30)	0.00 (0-30)	$\chi^2$ (2)=15.016, p=0.661			
ASI-Drugs	0.00(0.00-0.38)	0.02(0.00-0.50)	0.02(0.00-0.43)	$\chi^2$ (2)=37.216, p=0.005	Z=0.963, p=0.336	Z=0.124, p=0.901	Z=0.064, p=0.949
Days of drug use in past 30	0.00 (0-30)	0.00 (0-30)	0.00 (0-30)	$\chi^2$ (2)=34.742, p=0.010	Z=1.078, p=0.281	Z=0.632, p=0.528	Z=0.074, p=0.941

